DOCUMENT RESUME

ED 109 877 88 EC 073 444

AUTHOR Holliday, Frances B.; Olswang, Lesley B.
TITLE School-Community Program in Early Childhood Development.
INSTITUTION Evanston School District 65, Ill.
SPONS AGENCY Bureau of Elementary and Secondary Education (DHEW/OE), Washington, D.C.
PUB DATE 74
NOTE 121p.

EDRS PRICE MF-$0.76 HC-$5.70 PLUS POSTAGE
DESCRIPTORS Child Development; Cooperative Programs; Early Childhood; *Educational Diagnosis; Exceptional Child Services; *Handicapped Children; Identification; *Intervention; *Program Descriptions; School Community Relationship; *Screening Tests
IDENTIFIERS Elementary Secondary Education Act Title III; ESEA Title III; Illinois (Evanston)

ABSTRACT

Described is the Program in Early Childhood Development (PECD), a school-community project initially funded under Title III to provide identification, diagnostic, and intervention services for 3- to 5-year-old children in Evanston, Illinois prior to kindergarten entry. Two major sections deal with screening procedures (in such areas as social-emotional development, gross and fine motor perception, and cognition) and formal and informal diagnosis (in such areas as vision, hearing, speech, and language). Depending on the child's needs, it is explained that the program's intervention phase can consist of three alternatives: recommendations for remedial activities to be implemented by parents or preschool teachers; referral to a community agency for treatment; or enrollment in individual, small group, or multidisciplinary group therapy. A final section briefly covers information dissemination to kindergarten teachers and special services personnel. Sample history and evaluation forms are included in the screening section and in the appendixes. (LH)

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SCHOOL-COMMUNITY PROGRAM IN EARLY CHILDHOOD DEVELOPMENT

by Frances B. Holliday and Lesley B. Olswang

Evanston, Illinois

District 65 EVANSTON PUBLIC SCHOOL SYSTEM

EC 073 444

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Program in Early Childhood Development
Evanston Public School System, District No. 65
Evanston, Illinois

FIRST PRINTING

Library of Congress Catalog Card Number: 73-86803

The project presented or reported herein was performed pursuant to a Grant from the United States Office of Education, Department of Health, Education and Welfare. However, the opinions expressed herein do no necessarily reflect the position or policy of the United States Office of Education and no official endorsement by the United States Office of Education should be inferred.

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PREFACE

In July 1971, "A School-Community Preventive Intervention Program in Early Childhood Development", was funded (Title III, Sec. 306, ESEA) to Community Consolidated School District No. 65, Evanston, Illinois.

The overall project objectives were:

- To screen on a multidimensional, interdisciplinary basis virtually all pre-school children 3-5 years old, prior to kindergarten entry;
- To identify through diagnostic evaluation children for whom failure or problems in kindergarten are probable for necessary treatment and/or referral;
- To identify the talents and resources of handicapped children in the district;
- Through diagnostic evaluations, to initiate intervention programs to meet individually identified needs (physical, social, cognitive, language, and emotional) prior to kindergarten entry;
- To facilitate the coordination of efforts of a range of community agencies directed toward the amelioration or prevention of personal and social problems;
- To provide the administration and kindergarten teachers with information about the entering kindergarten children;
- To provide kindergarten teachers the necessary background to understand and take into account individual differences among their pupils.

Since the Program in Early Childhood Development (PECD) was initiated, a growing number of school districts along with State Departments of Education have turned toward preventive and intervention programs at the pre-school level.

With the passage of Illinois Public Law No. 323 (requiring school districts to provide treatment for handicapped preschool children, which became effective July 1, 1972) the Evanston program became a model of great interest throughout the state. At the present time District No. 65 is in compliance with the standards of that law as they are specified for the year 1975.

The purposes of this book are to answer inquiries from other districts as they plan for compliance with the law and to be helpful to school districts, departments of education, universities, and others concerned about pre-school screening and intervention.

More important is the overriding philosophy which we hope is adequately stressed; that our goal is to identify the relative strengths and weaknesses of the individual child and to prescribe instructional programs that will build on the strengths and supplement the weaknesses; that we forthrightly, minimize the likelihood of youngsters being "labeled."

Credit for the development of the Child Services Component screening procedures and instruments should rightly be given to all of the staff. In an open relaxed, yet determined situation, new ideas and suggestions were generated by all those present. However, specific individuals have exerted a great influence on the content of the screening instruments and the understanding by the staff of the concepts behind the screening procedures:

Mrs. Ruth Montague, while serving as Project Evaluator, helped to develop the Cognitive Screening Instrument and, additionally, assisted the staff in gaining a better understanding of the methodology for designing screening instruments. Mrs. Emily Fields, served as consultant during the developmental phase of the screening program. Dr. Carol Mardell and Mrs. Dorthea Goldenberg authors of DIAL (Developmental Indicators for the Assessment of Learning) generously shared their insights in the development of the screening instrument.

The diagnostic and intervention aspect is of course, the crux of the program. We are appreciative of the assistance in the development of the intervention model given by School District No. 65 kindergarten teachers, District No. 65 Special Services personnel and preschool educators in the community.

Special thanks to William Topaz, Secretary-Treasurer of the publishers of the *Journal of Learning Disabilities* (The Professional Press, Inc.) for his assistance in the publication of this book. We are grateful to the members of the Community Advisory Council who gave us their support. We acknowledge the valuable assistance given by the total staff, present and

past, in the overall development and implementation of the total program; namely, Linda Fair, Sue Bailey, Helen Johnson, and Barbara Roberts.

With pride and affection, we acknowledge the contributing authors on our staff, namely, Robert Blake, Ph.D., Psychologist; Iris Exelrod, Speech & Language Clinician; Iris Hudson, Nurse; and Rosemary Planz, Learning Development Specialist.

F.H.
L. O.

PART ONE:

INTRODUCTION

INTRODUCTION

During the existence of the Evanston, District 65, Program in Early Childhood Development from July, 1971, through January, 1973, approximately 1,000 pre-school children were screened. Of this total number, nearly 50% of the children exhibited *some* type of weakness, varying in degree of severity, in the areas of speech and language development, social-emotional development, vision and hearing acuity and/or learning readiness. Prior to the creation of this program, many of these problems remained unidentified, until the child entered school or had been attending school for some time. Late identification often resulted in developing frustration among these children and possible future failure in school. Further, District 65 Special Services Staff could not provide intervention services for all of these younger children. Although the Evanston community does have a variety of resources, all areas of need were not being met. The Program in Early Childhood Development (PECD) attempts to bridge the gap between already existing resources in the school and community and the needed services for pre-schoolers. Authorities agree that the pre-school years are key learning years and should not be overlooked as an appropriate time for short term intervention and/or prevention programs. Thus, the statement of need is clear; the existing population of pre-schoolers with possible weaknesses need to be identified, and with the identification of weaknesses, services for remediation must be provided.

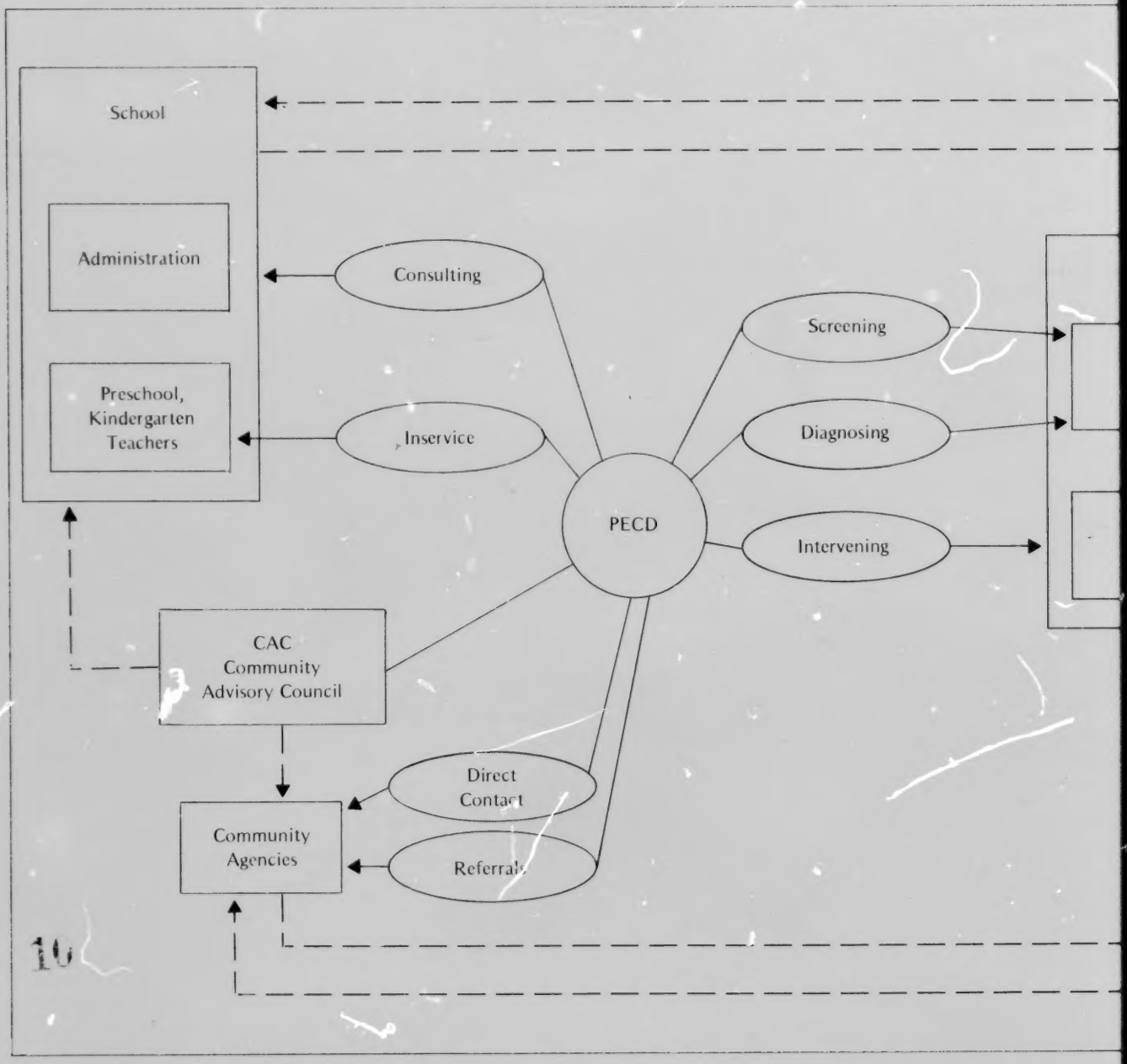
The program is further designed to create a better fit between the child entering school and the school itself. This means bringing about changes in the schools to better meet the needs and strengths of all children in the community as they enter the school system.

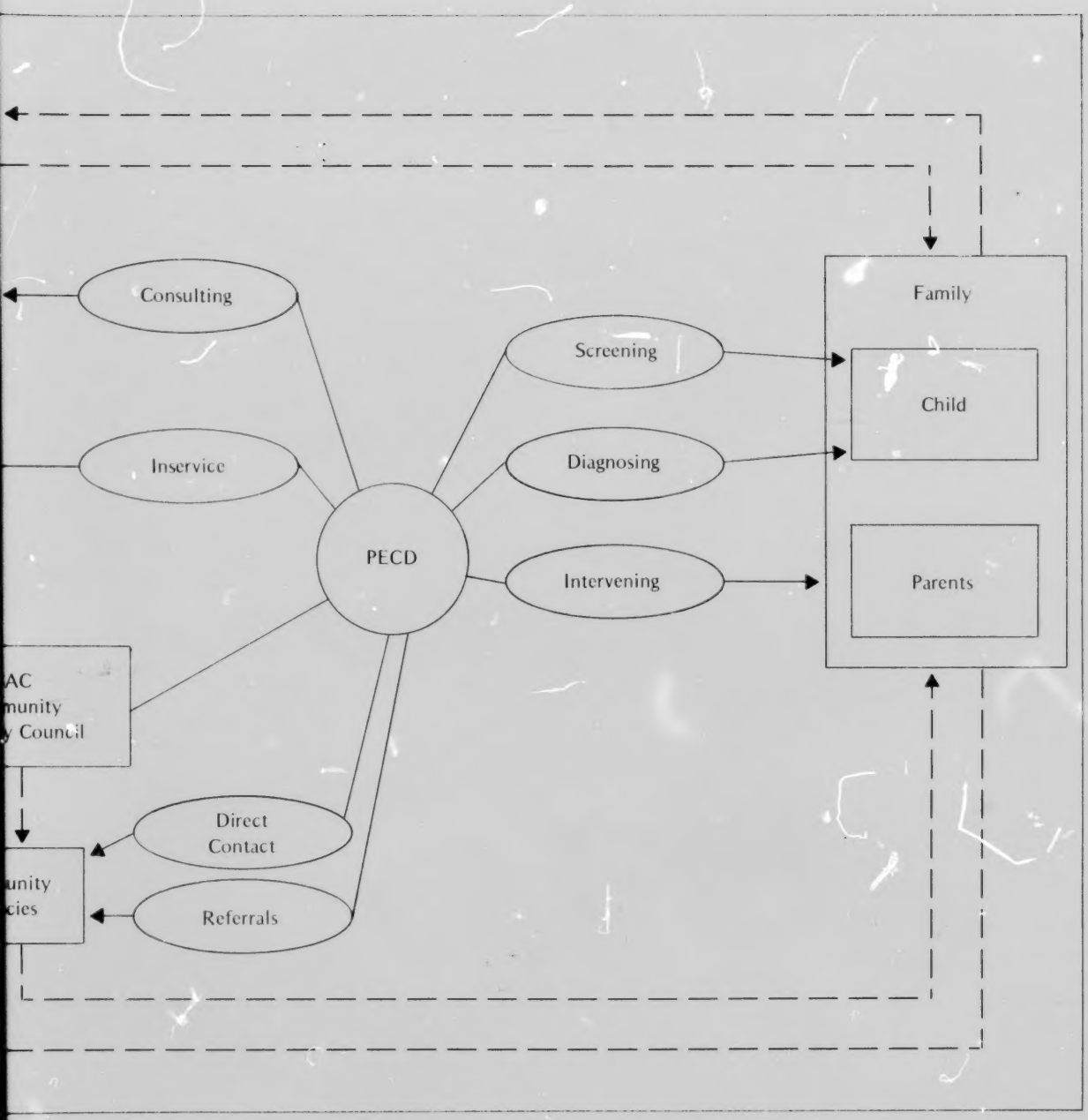
By administering a screening instrument to all children prior to kindergarten entry, the Program hopes to identify each child's individual strengths and weaknesses as related to physical, social, cognitive, language, and emotional development and skills. The following specific areas are incorporated in the screening: Gross Motor/Perceptual Development, Fine Motor/Perceptual Development, Cognitive or Learning Development, Speech and Language Development, Social-Emotional Development and Vision and Hearing Acuity. The program provides further diagnostic evaluations for children exhibiting weaknesses in these developmental areas. When appropriate, the PECD Staff provides intervention in the form of individual or group therapy, recommendations to parents and teachers, and/or referral to Evanston agencies for additional services. Relative to the identification of strengths and weaknesses, information and recommendations are made available to kindergarten teachers when the children enter school. It is through this model that the program hopes to aid in the development of each pre-school child's potential abilities so he is more likely to have his school experience a successful one in terms of his goals and those of his family.

In an effort to provide child-services continuity, in-service seminars and practicums have been provided for pre-school, Headstart, and kindergarten teachers and paraprofessionals. These seminars have been organized to (a) present a body of information on physical, cognitive, language and affective growth and development within a multidisciplinary framework, (b) to assist kindergarten, pre-school and paraprofessional teachers to identify, describe, and analyze ethnic, racial, cultural and organizational obstacles within the school which prevent compatability between the child and the school, (c) to develop a specific project designed to eliminate or improve compatability between the child, the school and the community, (d) to plan a learning program, designed to assist in the development of the pre-school kindergarten child's potential abilities, including diagnosis and assessment.

The Program also functions as a coordinating and liaison vehicle through which community agencies, already working at providing special services for children of pre-school age, can maximize their efforts through formal cooperation with the school district. PECD refers to and accepts referrals from such agencies and plans to continue to develop a working model for community-school-family services. The foundation for such a model is the Community Advisory Council, composed of representatives from the community for purposes of coordinating program activities with the community.

The following diagram illustrates the processes through which the Program is attempting to impact the Evanston Community: schools, agencies and families:


School
Administration
Preschool, Kindergarten Teachers
Consulting
Inservice
PECD
Screening
Diagnosing
Intervening
CAC Community Advisory Council
Direct Contact
Referrals
Community Agencies


Consulting
Inservice
PECD
Screening
Diagnosing
Intervening
Family
Child
Parents
AC
munity
y Council
Direct
Contact
unity
cies
Referrals

STAFF POSITIONS

The PECD Staff and their primary responsibilities include: (1) *Program Director* – overall responsibility for meeting program objectives, coordination of program activities, and public relations; (2) *Program Coordinator and Curriculum Developer* – coordination of the screening, diagnosis and follow-up activities; coordination of relations with pre-school personnel; provide assistance to teachers in developing curricula which facilitate maximum child growth and development; (3) *Program Evaluator* – assist in the collection, organization and treatment of data, and modification of the evaluation design in progress; evaluation of the achievement of overall and specific program objectives; assist in the interpretation of data and the preparation of reports on the evaluation findings; (4) *Psychologist* – provide follow-up activities for children as indicated by the Social-Emotional screening information; assist families regarding referrals to community child service agencies; assist teachers in their consultations with families; develop parent program; (5) *Nurse* – secure medical history and current status information on health, vision and hearing necessary for the pre-school screening process; develop parent program; (6) *Learning Development Specialist and Educational Therapist* – responsible for cognitive, fine motor, perception, and gross motor assessment of pre-school children; provide intervention through individual therapy or referral, as indicated; (7) *Speech and Language Clinician* – responsible for assessment of communication skills of pre-school children; provide speech and language therapy for children, as indicated; (8) *Professional-in-Training* – assist in working with children in intervention portion of program; serve as liaison between program and community; help coordinate activities of various program components with defined responsibilities; participate in staff meetings, and other activities related to program implementation; involvement in data gathering from the community-at-large, community service agencies, and community organizations.

The information that follows presents a detailed description of the Child Services Component, which is composed of the Screening, Diagnosis, and Intervention model. It is based on this model that the PECD Staff has attempted and will attempt to make the kindergarten experience a successful one.

PART TWO:

SCREENING

General Attributes of the Screening Program

CHAPTER 1

"A child's first five years are crucial ones because of the rapid development which takes place during this time. Influential educational groups such as the Educational Policies Commission and the National Society for the Study of Education, as well as workers in a variety of disciplines, have attested to the importance of this period by giving special consideration to it. A study of the research reveals that these years before six are recognized as critical ones for educational growth."[1]

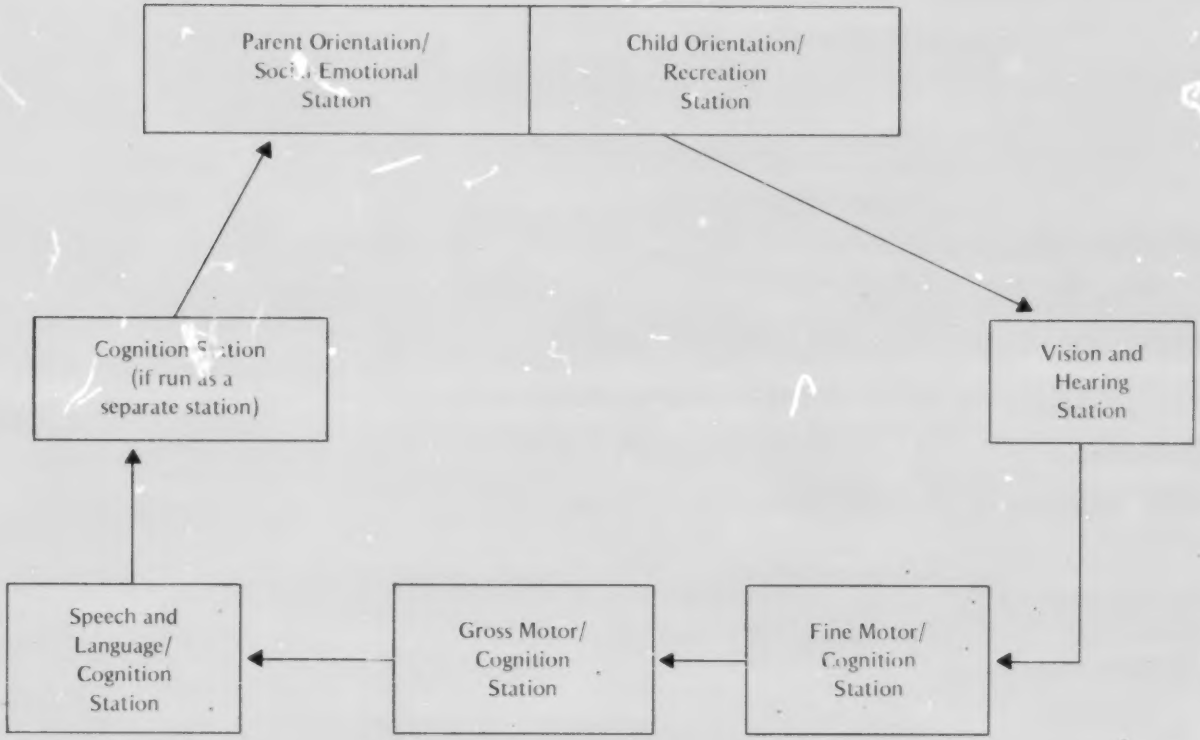
Following this philosophy, the PECD Screening is designed to measure certain abilities for which there is empirical or theoretical evidence relative to school success, and for which intervention services could be provided, if deemed necessary. Included in the screening program are instruments to measure physical (vision and hearing), cognitive, gross and fine motor, speech and language and social-emotional development.

All pre-school children living within the confines of School District No. 65 are invited to participate in the screening prior to kindergarten entry. The primary target population each year includes all children entering kindergarten the following fall. A secondary target population includes the remaining children, three to five years old, whose parents or pre-school teacher requests the screening, due to a concern about the child's development.

Since the beginning of this program, much time has been spent in the community discussing with pre-school teachers, parents of pre-kindergartners and community agencies, the importance of early childhood development and the worthwhileness of a screening, diagnostic, and intervention program. It was with this foundation that the PECD devised a screening model in which parents arrange for an appointment and bring their children to a central screening location. In this way, the PECD facilities are utilized for screening, as opposed to obtaining sites throughout the community as done in the past. This procedure saves considerably on time spent in finding and arranging for sites, transporting materials, and for setting-up the physical screening structure itself.

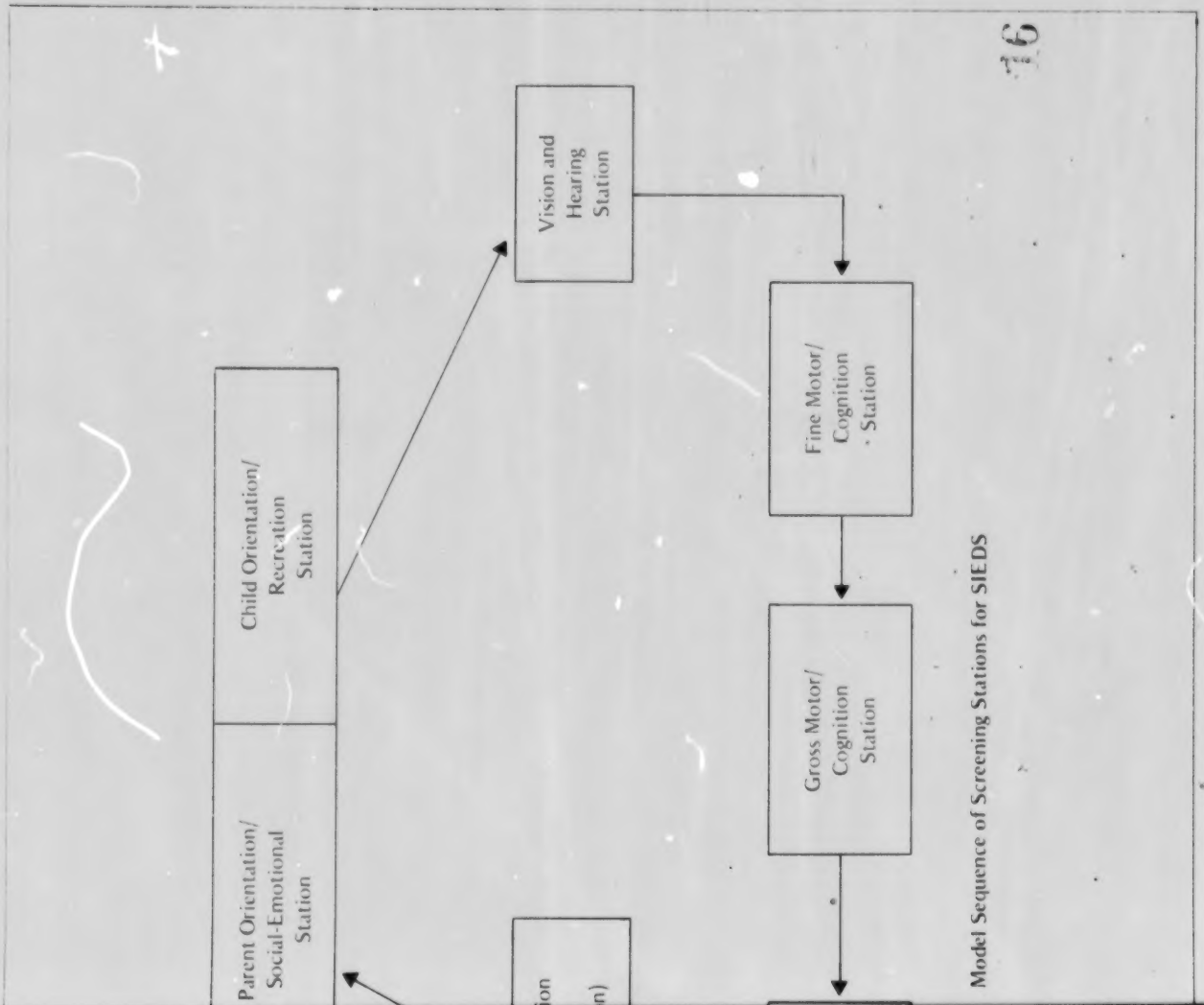
Details of the screening model are as follows: Mondays, Tuesdays and Wednesdays are utilized for intervention at the PECD Learning Center and/or at Pre-School Center sites throughout the community, such as Headstart and various day care sites. Therapy is terminated at 2:30 p.m. on Wednesdays to allow for team therapy planning and for staff meetings as they arise. All day Thursdays, and Fridays until noon are designated as screening times. Periodically, screenings is also held on Saturday, for the convenience of working parents. Appointments for screening are made by calling the PECD Office; the screening schedule includes approximately six (6) appointments per hour between 9:00 and 11:30 a.m. and 1:00 and 3:00 p.m. The children are screened on an individual basis by the Program Staff. As illustrated in the diagram on page 4, the children pass from one screening station to the next, each of which includes different tasks for the child to perform. The total screening time for each child averages about forty minutes. The instruments used at each screening station are described in detail on the following pages. Following Friday morning screening, time is alloted for staffing children that were screened and for diagnostic planning. Friday afternoons are utilized for diagnostic evaluations of children exhibiting weaknesses on the screening.

As mentioned, following screening, the staff meets to exchange and interpret the data gathered for each pre-school child who participated in the screening. At this time, the strengths and weaknesses of each child are noted and recorded. For children who exhibit severe weaknesses in one or more areas, or demonstrate a complex pattern of weaknesses, recommendations are made by the Staff, with regard to further diagnostic testing, parent/teacher conferences, or other necessary types of intervention. The procedures for this Screening Staffing will be discussed in more detail at the conclusion of this section.



Model Sequence of Screening Stations for SIEDS

As approximately twenty-five (25) children can be screened in one day, this format, as described, allows the PECD Staff to screen virtually all children who will be entering kindergarten the following year, plus any younger children referred due to parental or teacher concern. It is believed that this procedure enables the Program to reach a large number of children, and yet leaves time for consistent and concentrated therapy programs.


Parent Orientation/ Social-Emotional Station
Child Orientation/ Recreation Station
Vision and Hearing Station
Fine Motor/ Cognition Station
Gross Motor/ Cognition Station

Model Sequence of Screening Stations for SIEDS

Screening Instrument for Evaluating Developmental Skills

CHAPTER 2

The Program in Early Childhood Development was initially funded in the Summer, 1971, under Title III ESEA (Elementary and Secondary Education Act), of the Department of Health, Education and Welfare. During the first several months of existence, the Staff spent a considerable amount of time researching existing pre-school test instruments in the various disciplines. None of these existing devices in total met the needs of the program, either because of their length, content, or philosophy. It was following this research that the PECD Staff developed the Screening Instrument for Evaluating Developmental Skills, hereafter referred to as SIEDS. The SIEDS was based upon existing developmental norms in the areas of Speech and Language, Fine Motor, Gross Motor, and Cognitive Development. In addition, tasks were selected for inclusion on the screening instrument that would evaluate the pre-school child's perceptual skills. " 'Perceptual development' a term synonymous with 'learning to learn' means the process by which the organism builds basic information – processing strategies needed to learn other skills and information."[2] Primarily visual perceptual tasks were included in the Fine Motor and Gross Motor areas. "Because visual perceptual development is so basic to cognitive processes, we could expect poor development in this area to result in poor learning potential."[3] The SIEDS was designed to be administered quickly and easily, and to provide information about the individual child's strengths and weaknesses, and not for identifying the gifted or retarded child.

To date the SIEDS has proven to be very effective in identifying children with weaknesses of varying types and degree. It has also provided sufficient detail of the child's abilities, to be able to plan a program of individualized instruction based on the child's strengths as demonstrated during the screening. Age norms for the SIEDS will be available as a supplement to this publication and on request.

The following pages describe in detail the content of SIEDS. The six screening areas are administered in stations and will be discussed as follows: Social-Emotional, Vision and Hearing, Fine Motor/Perception, Gross Motor/Perception, Speech and Language, and Cognition. The score sheets for each station are located at the end of the explanation for each area.

Social-Emotional Station

CHAPTER 3

The parent is always urged to bring the child to the screening for several reasons. First, this provides an opportunity for the staff to observe the interaction between the parent and child. Secondly, in addition to collecting some basic, clerical information, the major portion of the Social-Emotional Evaluation is based on the parent's responses to a questionnaire. Thirdly, should the child become reluctant to participate, the parent may accompany the child through the screening. Finally, the parent is requested at this time to sign a consent form permitting the PECD information to be released to the School District. The procedure is for a parent to accompany the child to the screening. If, however, this proves to be an unrealistic demand on a parent, alternative arrangements are made. For example, often times a pre-school teacher and/or director can arrange for several children from the school to be brought to the screening site and the parent information is then obtained through the school. Saturday screenings are also provided to aid the working parent.

At the orientation station the child is given a name tag with his name, birthdate and an identification number on it. (The Identification Number is composed of the screening site number plus the child's numerical assignment.) He is then directed to a play table with other children, where they are informed about the various games that they will play in the screening room. Providing this basic information to the children has helped to make them feel more comfortable in the new setting. Further, this situation provides an opportunity to observe such things as the child's social language, relationship with parent and social activity with peers.

The parent proceeds to another table where she is instructed to complete an information form (page 10), the consent form (page 12), and the Social-Emotional Questionnaire (page 13). The Social-Emotional Instrument was developed in the summer of 1972, by Dr. Robert Blake, Staff Psychologist. The PECD Nurse and/or Psychologist collect the general observational information, and are available at this time to discuss any concerns that the parent might have regarding her child.

The information obtained from the parent, plus the general observational information is added to the more formally measured results of the other stations. This adds more qualitative information.

CHILD BEHAVIOR PROFILE

The purpose of the Child Behavior Profile is to determine in a rather gross way, whether a family should be recontacted to determine if the child has a social or emotional problem. The Profile consists of twenty-six behaviors observable in children. Parents are asked to fill out the rating scale to the best of their ability by circling one number on each scale item which most closely reflects the behavior listed below the number. It is possible for parents to make their children "look good" on the rating scale to some degree by marking all the items in the middle or marking statements that sound favorable toward them and their child. This tendency can be checked by a quick look at the scoring sheet. The fact that there seems to be a high correlation, however, between the behavior of the child when he is brought to the screening and the behavior attributed to the child by the parents, indicates that most parents will try to give accurate information in exchange for an honest appraisal of their child. In addition, the direction of wording on the seven point scales is varied to compensate for any tendency to mark only one side of the page.

The Profile is scored in five subscales: Physical Expression of Maturity, Independence, Emotional Stability, Parent-Child Relationship, and Social Interaction. On the Behavior Profile Score Sheet (page 16), the five subscales are listed. Below each of them, vertically, are listed the numbers corresponding to those statements (individual seven point rating scales) that are related to that particular subscale. (For example, scales 1, 5, 10, 12, and 15 are related to Physical Expressions

of Maturity). The scorer merely marks the parent's answer for each scale in the appropriate space, totals them and finally, plots that total on the profile. The profile score sheet is graphed so that the mean score falls on the middle line. The dotted lines indicate standard deviations above and below the mean line. Any child who has a single score above or below the second set of dotted lines should be called for further exploration. Any two scores *above* the first dotted line and any child with an elevated scale IV, should be called. The score sheet is standardized on a population of 547 lower, middle, and upper class, multiracial children, four to five years old.

When the subscales are understood, they can be used to give some systematic feedback to parents about how they see their children. If, in the follow-up contact with the family, there are obvious problems, further diagnostic interviewing and therapy for the child and family is in order. Formal testing is probably unnecessary, since the family has already said there is a problem by giving the information on the form, and is willing to talk about it.

Individually the five subscales can be interpreted as follows:

Scale I: Physical Expressions of Maturity

This scale attempts to measure the degree to which physical symptoms occur in children which may reflect underlying emotional concerns. Since in small children emotional and physical issues are hardly distinguishable, this scale also can be seen as a developmental estimate of something called "general maturity." For instance, the child who sucks his thumb constantly at age three and a half would be viewed differently if he did the same thing at five and a half.

The child who scores high on this scale may not use physical symptoms to cope with emotional stress and may seem overly "grown up for his age"; a child not generally seen as having any unmet needs.

The child who scores low on this scale either has specific underlying emotional needs which are being expressed in some outward physical way, has ongoing physical problems, or his general ability to cope is not what would be expected from a four or five year old child.

Scale II: Independence

This scale measures the child's internal sense of autonomy. If the child scores high on this scale, the autonomy may be in extreme forms of self reliance; the child may be seen as very aggressive and possibly hostile. Most likely this behavior will have to be interpreted in the light of the scores on the other scales.

The child who scores low on this scale will probably be seen as shy, withdrawn, and uninhibited, generally summarized as having low self confidence.

Scale III: Emotional Stability

This scale is a measure of the mood swings or emotional lability in a child. The child who scores high on this scale may be subject to unexplained outbursts of anger or crying, may have many fears, and be difficult for parents to reassure.

A child who scores low on this scale tends to be no problem to parents but shows little or no emotion and does not easily establish relations with other people.

Scale IV: Parent-Child Relationship

This scale measures the amount of tension which the parent feels in relation to his child. A child who scores high on this scale may be of great concern to his parent(s). It is probably this very tension between the parent and child which is adding to or causing problems for the child.

The child who scores low on this scale probably reflects one of two things. The parent who filled out the form can be filling out the questionnaire in a manner which makes the child "look good" or the low score can indicate a child who possibly spends much of his time trying to please adults, in order to gain acceptance and approval.

Scale V: Social Interaction

This scale measures the manner in which the child interacts with groups of peers. The child who scores high on this scale often is extremely active in groups and will tend to be very aggressive in social situations.

The child who scores low on this scale will tend to play alone, will be quiet, and avoid play groups which involve either cooperation or competition.

The interpretation of the scores on the subscales either to the screening staff, to parents, or teachers must be done in terms of the overall pattern on all of the subscales. While the individual interpretations of the scales given here are correct in isolation, their meaning takes on a new context and significance when seen in the light of the whole profile. Experience and use of the scale will enable a fuller and more meaningful interpretation of each of the subscales.

On the whole, however, the graphing of the profile reflects a

general extroversion vs. introversion behavior style. Scores falling in the top half of the profile generally reflect an outwardly expressive mode of dealing with emotional and social issues: "I can do it myself" attitudes, emotional outbursts, good health, upset parents, and aggressive social interaction. Scores falling in the bottom half of the profile generally reflect a turning inward mode of dealing with emotional and social issues: shyness, extreme concern to please adults, lack of social interaction and poor health.

SCREENER CHECK LIST OF BEHAVIOR

In addition to the Child Behavior Profile the evaluation of the social-emotional adjustment of the child is based on the behavior observed during the total screening. Each Staff Member screening the child in any area writes down her own comments concerning behavior which she feels is significant. This information is collected in a systematic way so that several different views of the same child can be compared.

The Screener Check List of Behavior consists of a rating scale from one to five on three different dimensions, they are: Effort Toward Task, Self Confidence, and Social Interaction (See below.) The three rating scales appear at the bottom of each of the score sheets. Each Staff Member that administers a screening area completes the check list on each child. The points on the scale are described by specific behaviors in order to facilitate the screener quickly checking the appropriate place and in order to gain continuity concerning the definitions of the scales across several screeners.

The Check List is set up in a manner similar to the Child Behavior Profile on generally introvertive vs. extrovertive mode. The child receiving check marks on the left hand end of the scale tends to reflect an internal handling of social and emotional issues, while those receiving check marks on the right hand end of the scale tend to reflect an external mode of handling social and emotional issues.

The information obtained from the Screener Check List, plus any additional comments or observations made by the Staff, are discussed during the staffings following screening, and are used as another criteria for follow-up in the Social-Emotional Area.

SCREENER CHECK LIST OF BEHAVIOR

The following scales appear on the bottom of each score sheet and are completed by the Screening Examiners for each child.

Effort toward task	1 Won't Quit	2 Works overly hard	3 Attentive	4 Works with constant reminding	5 So distracted can't do task
Self Confidence	1 Constantly seeks assurance	2 Eager to please	3 Assured	4 Mind of own	5 Refuses or says "No"
Social Interaction	1 Will not respond	2 Minimal responses	3 Cooperative	4 Aggressively sure	5 Hostile

DISTRICT No. 65 PROGRAM IN EARLY CHILDHOOD DEVELOPMENT

DATE _____

NAME OF CHILD _____ SEX _____

DATE OF BIRTH _____

PARENT OR GUARDIAN _____

ADDRESS _____ TELEPHONE NO. _____

Is child presently receiving services from a Medical or Social Agency? Yes _____ No _____
If so, what agency? _____

Is child presently enrolled in a pre-school? Yes _____ No _____
If so, what school? _____

Language spoken in the home? _____

Will child enter kindergarten this coming fall? Yes _____ No _____
If so, what school? _____

Are there any other children in the family? Yes _____ No _____

NAME	AGE
_____	_____
_____	_____
_____	_____

Please describe any concerns that you might have for your child in the areas below:

VISION _____

In addition, do the eyes look crossed or does one eye wander away from the object at which the child is looking, particularly when ill or tired?

HEARING: _____

PHYSICAL SKILLS:_____

SPEECH AND LANGUAGE:_____

PERSONAL AND SOCIAL DEVELOPMENT:_____

WOULD YOU LIKE TO MAKE AN APPOINTMENT WITH THE PSYCHOLOGIST? Yes___ No___
WHY?_____

IS THERE ANY ADDITIONAL INFORMATION THAT WE SHOULD KNOW ABOUT YOUR CHILD?

PROGRAM IN EARLY CHILDHOOD DEVELOPMENT

DATE _____

I, _____ (Father / Mother / Guardian) of _____ (child's name)

hereby give my consent to the Program in Early Childhood Development to give information regarding

_____ (child's name) to District No. 65 (Evanston Public School System).

Signed: _____

Address: _____

PROGRAM IN EARLY CHILDHOOD DEVELOPMENT

CHILD BEHAVIOR PROFILE

The following questions are meant to help you, and us, think about the behavior of a particular child. There are no right or wrong answers. The questions are meant to provide a better understanding of how a particular child deals with the world around him.

It will be most helpful and accurate if you answer as honestly as you can but without spending too much time on any question. First impressions are usually accurate. You can always go back and change an answer after you are done if you wish to do so.

The items are arranged on a scale from 1 to 7. Circle the number on the scale that represents where this child is on the scale. On some items a child will be high, on others low, on others in the middle, depending on his or her own personality.

	1	2	3	4	5	6	7
1	Child wants to be smaller			Likes present size		Child wants to be much bigger	
	1	2	3	4	5	6	7
2	Never disobeys parents or other adults			Usually cooperative but some arguing		Will not mind at all	
	1	2	3	4	5	6	7
3	Never cries			Cries sometimes		Cries three (3) times a day or more	
	1	2	3	4	5	6	7
4	Will not play alone			Plays easily by self or with others		Always plays alone	
	1	2	3	4	5	6	7
5	Wets the bed two (2) or more times a week or not toilet trained.			Occasionally has accidents or wets the bed.		Can't remember child ever wetting bed or having an accident.	
	1	2	3	4	5	6	7
6	Gets in fights or big arguments 4 times a week or more; loses temper for no reason			Stands ground when treated unfairly		Never has been in a fight or argument; doesn't stand up for rights	
	1	2	3	4	5	6	7
7	Can't stand being told what or how to do it.			Accepts direction easily but likes to work on own.		Will not try without being encouraged.	

	1	2	3	4	5	6	7
8	Always gets own way at home or controls every group			Sometimes dominates; sometimes left out		Gets left out of groups or family activities	
9	Does not talk			Normal amount of talking		Never stops talking or yelling	
10	Can't remember child ever sucking thumb or fingers			Sometimes sucks thumb or fingers		Hardly ever takes thumb or fingers from mouth	
11	Sees parents or adults arguing every day			Sometimes sees parents or adults arguing		Has never seen disagreements between adults at home	
12	Can't sit still; jumps from one thing to another, no attention span			Has usual attention of child his age		Works for long periods on own projects	
13	Deliberately tries to make me angry or upset			Sometimes makes me angry		Never does anything to make me angry or upset	
14	Projects are sloppy never completes anything started			Carries through on most self-initiated projects		Projects must be done perfect, gets upset when not perfect	
15	Never sick or has small injuries			Sick or has small injuries about two times a month		Complaints of physical ailments or injuries 2 times a week or more or has an on-going medical problem	
16	Never acts silly or shows off			Sometimes acts silly or shows off		Always acts silly or shows off	

	1 2	3	4	5	6 7
17	Very aggressive		Not aggressive; no self doubt		Lots of self doubt
18	I really treat this child badly		Sometimes I act well, sometimes bad toward this child		I have never wondered if I am treating this child right
19	Does not like being around other people		Doesn't care if alone or with others		Afraid to be left alone, even for a short time
20	Reminds others of rules when playing; plays parent role		Plays many role with playmates		Cannot control behavior or obey rules when playing with others
21	Shows little emotion, even when it might be expected		Shows emotion as might be expected for a child this age		Easily upset; has strong outburst for little or no reason
22	Child never does anything unexpected		Behavior is normal		Child does some very strange things
23	Unwilling to compete; upset by games where child might lose		Tries hard but doesn't care about results		Always tries to show up the best; always competing
24	Brags about body. strong beautiful, tall, etc.		Doesn't talk about body		Often expresses dislikes for body; ugly fat, stupid, etc.
25	This child upsets me most of the time		Once in a while I am upset with this child		I have never been upset with this child
26	Reckless; has no sense of danger		Careful around dangerous things or activities		Overly frightened or scared of being hurt or injured

BEHAVIOR PROFILE

SCORE SHEET

DATE _____

NAME _____

33	34	23	31	32	
30	30	20	28	29	
26	27	18	26	27	
23	24	15	23	24	
20	20	13	20	22	
16	17	11	17	19	
13	14	8	15	16	

Physical Expressions of Maturity	Independence	Emotional Stability	Parent-Child Relationship	Social Interaction
1 _____	6 _____	3 _____	2 _____	4 _____
5 _____	7 _____	15 _____	8 _____	9 _____
10 _____	11 _____	20 _____	13 _____	14 _____
12 _____	17 _____	21 _____	18 _____	16 _____
15 _____	24 _____		22 _____	19 _____
	26 _____		25 _____	23 _____
_____	_____	_____	_____	_____
TOTALS				

Vision and Hearing Station

CHAPTER 4

"Early identification of visual problems may prevent later failure in school work because of inability to perform the tasks required."[4] Since vision defects play a major role in a child's learning, and with a view toward early identification, vision screening is undertaken in order to ascertain if the child has any visual limitations. The Michigan Junior Screener and/or Stycar Chart are the instruments used for vision screening.

Impaired hearing affects not only the development, but also the lifetime use of language communications skills. Fortunately, an assessment of hearing can be made very early in the child's life. Hearing screening is therefore provided; this screening is undertaken in two stages. The purpose of the first stage, called sweep screening, is to identify: "(1) those children who have no hearing problem; and (2) those children who are suspected of having a hearing loss. The second stage involves a more detailed test, known as the threshold test. The purpose of the threshold test is to either confirm or nullify the screening test results and lead to a medical and educational referral, if indicated."[5] The equipment used for hearing screening is a Beltone audiometer with ISO standards.

The Evanston North Shore Health Department offers vision and hearing screening to children enrolled in Evanston pre-school centers. Pre-school children who do not attend a pre-school center, or if they do, were absent the day of the screening, are screened by the PECD Nurse, when they participate in the complete PECD screening program. She coordinates with the Health Department the records for all children who have been screened in the areas of vision and hearing for follow-up purposes and is responsible for the eventual dissemination of information to the school system. The Vision and Hearing screening should be administered by the Nurse or an individual trained in the administration of such tests.

VISION AND HEARING STATION

TASK	DIRECTIONS FOR ADMINISTRATION AND SCORING
1. Vision screening – to measure visual acuity, or "the sharpness of vision in respect to ability of the eye to distinguish detail as an object is placed farther away or as it becomes smaller in size." The three and four year old child should have an acuity of 20/40, the five year old child should have an acuity of 20/30.	1. Prior to actual screening, the teaching game consisting of flash cards can be used to prepare the child. A variety of training methods may be used with the cards depending upon the instrument used. Place the instrument against or near a wall, either on its own adjustable stand or on a low table. There should be no intense light sources within the child's field of vision as he looks at the chart. Mark the child's position with an outline of two small shoe prints by carefully measuring ten (10) feet or twenty (20) feet, depending upon the type of chart used, from the surface of the chart to the tip of the toes. Small paper cups may serve as occluders. a. Observe the child as he comes toward you and as he looks at the teaching card you show him.

b. Let him sit or stand while he tells you about the *Es* (tables) on your big card one at a time.

c. Play "peek game." Show him how by placing a cover (cup) over your own eye if necessary.

d. Place cover over his left eye while he tells you about six (6) *Es* (tables). Place cover over right eye and do the same. If child cannot cooperate, walk up to the chart to be sure that he understands. Record the scores on score sheet or card, for both eyes, right and left eye.[7]

a. Michigan Junior Screener (Good-Lite, Forest Park, Illinois)

a. Play the game by asking the child to name the picture (Bunny, Clouds, Grass, Flower) to which the *E* (table) is pointing, or to place his hand in the direction of the *E* (table), or give the child a wooden or cardboard *E* and ask him to make his "look just like mine" on the picture.

b. Stycar Test Chart (Good-Lite Company, Forest Park, Illinois) (Based on "Snellen Letters as Matching Objects" by Otto Lippmann, M.D.)

b. Play the game by having the child place his hand over or point to the symbol on his response panel to indicate which one matches the symbol shown on the instrument. Care is taken not to call the letters by name, as child has only been taught to match symbols.[8]

Record the number of symbols correctly reported by both eyes, right and left eye (a possible 6 for each). If child cannot "play the game," record "untestable." Record any observations. Inability to correctly report four of six symbols with both eyes, right and left eye necessitates re-screening within a week or as soon as possible. Ask the parent to play the *E* game a few minutes each day until the next appointment. If a child seems to cooperate, but fails and if the family history indicates eye trouble, make an immediate referral for a complete eye examination.

2. Hearing Screening – to measure hearing acuity, the sharpness, clearness, or distinctness with which one is able to hear a sound. The child will respond to the frequencies of 500, 1000, 2000, and 4000 Hz at an intensity of 25 dB.

2. In this area, the child is conditioned to respond to a sound. The child is taught to "play the game" by responding to audiometric tones by raising his hand, by dropping blocks or clothes pins into a basket, putting pegs into a peg board, or any toy or game which will hold the interest of the pre-school child. The tester demonstrates the test and then teaches the child to respond through practice until he has the idea. Place the earphones on the table near the child and present test signals of 2000 Hz at 90 dB. The method of response is then demonstrated and after several demonstrations the child is encouraged to take his turn. After the child begins to respond correctly, place the earphones on his ears.

a. Using an audiometer, set the frequency selector dial at 1000 Hz and the hearing level dial at 25 dB (ISO).

b. Test the right ear at 1000, 2000, and 4000 Hz.

c. Switch the tone to the left ear leaving the frequency selector at 4000 Hz.

d. Test the left ear at 4000, 2000, 1000, and 500 Hz.

e. Switch the tone back to the right ear, leaving the frequency selector dial at 500 Hz.

f. Test the right ear at 500 Hz.

g. If a child fails to hear any tone at 25 dB, you should immediately raise the level to 35 dB and present it again. If the child responds at the 35 dB level, move on to the next test frequency and present the tone at 25 dB. An exception to this rule must be followed when this occurs at the first frequency being tested (1000 Hz in the right ear). The procedure for this situation is to return to 25 dB and give the child a second attempt to respond. If he then responds to 25 dB, this should be considered the true response and the initial failure to respond should be disregarded. At the first and second screening, record only pass or fail for each ear. For threshold testing, for each ear record the lowest hearing level at which the child responds at least 50% of the time (250-8000 Hz). A child is considered to have failed the screening test, if he fails to hear any one tone at 35 dB in either ear or fails to hear any two tones at 25 dB in the same ear. A child who fails should be given another screening identical to the first using the same criteria. A child who fails the second screening should immediately be given a threshold test. A child is considered to have failed the threshold test and is referred for a medical examination if the following criteria are met: (a) a hearing level of 30 dB or greater at any two tones in the speech range (500, 1000, 2000 Hz) in the same ear, or (b) a hearing level of 40 dB or greater at 250 Hz and 30 dB or greater at 500 Hz in the same ear, or (c) a hearing level of 30 dB or greater at 2000 Hz and 40 dB or greater at 4000 Hz in the same ear, or (d) a hearing level of 40 dB or greater at both 4000 Hz and 8000 Hz in the same ear.[9]

Fine Motor/Perception Station

CHAPTER 5

As the PECD Staff's research for the development of the SIEDS was completed, it became increasingly clear that tasks pertaining to fine motor development would be included on the screening instrument. This was done with the understanding that the emergence of certain fine motor skills, as the baby's grasp for a block, or the more advanced skill of placing pellets in a bottle,[10] provide us with a set of guides for evaluating yet another aspect of the child's development. Further, the development of fine motor abilities, eye-hand coordination and small muscle manipulation, are vital to the development of learning readiness skills. In order for a child to be able to perform successfully on rather complex fine motor tasks, particularly handwriting, he must be able to master elementary fine motor tasks, such as folding, stringing beads, puzzle completion, etc.

The Fine Motor/Perception Station includes tasks that are multidimensional in terms of their diagnostic value; the area, naturally involves considerable overlapping of tasks involving fine motor, cognitive and perceptual abilities. For example, in evaluating the child's manipulative skills in puzzle completion, we are also examining his eye-hand coordination, and his ability to match shapes and colors. In this way, information is obtained about more than one aspect of the child's development.

The Fine Motor/Perception screening takes approximately ten (10) minutes and is administered by the Educational Therapist or an individual with training in early childhood education.

FINE MOTOR/PERCEPTION STATION

TASK	DIRECTIONS FOR ADMINISTRATION AND SCORING
1. *Puzzle Matching:* measures eye-hand coordination, shape recognition, form perception, color recognition, manipulation, speed and dexterity. *Materials:* puzzle consisting of 2 shapes of each: circle, rectangle, square, triangle. *Each* piece and background is a different, matching color.	1. Present completed puzzle to child. Say, "Look at the puzzle. You take all the pieces out and then put them back in just like they are." Note: speed, manipulation, hand used. Child receives one (1) point for each shape matched correctly and one (1) point for each color matched correctly. Total: 8 points.
2. *Blocks:*[11] measures eye-hand coordination, spatial relationships and visual memory. *Materials:* Twelve (12) blocks the same color.	2. a. Make a 3 block pyramid (2 blocks as base, 1 on top). Leave model. Give 3 blocks to child and say, "Make one like this." b. Knock pyramid down and then make 6 block pyramid, spacing blocks (3 blocks as base, 2 on next level, 1 on top). Leave model. Give child 3 more blocks and say, "Make one like this." c. Knock pyramid down and then make a 6 block, 2 step structure (6 blocks stacked 3, 2, and 1) and say to child, "Make one like this."

d. Knock steps down and *remove* blocks from child. Take 4 blocks, put three (3) in a row and one on top of end block to make a train. Push train along and say, "This is a play train, choo choo." Disassemble train, give child same blocks and say, "Now you make a train just like mine."

Note: speed, manipulation, structure, memory.

Child receives one (1) point for each correct structure that he makes.
Total: 4 points.

3. *Stringing Beads:* measures child's fine muscle control and eye-hand coordination.

Materials: 2-foot string with knot at one end, and 4 beads of varying shape and size.

3. Give the child the string and four beads. Say, "Put the beads on the string."

Note: speed, manipulation.

Child receives one (1) point for each bead placed on the string.
Total: 4 points.

4. *Figure-ground perception:* measures ability to see foreground from background (or vice versa) and to trace around picture without being distracted or confused by extraneous lines.

Materials: Two black, block outline drawings of a moon, (Illustration A) each on a separate piece of paper and facing a different direction. One moon is covered by 1/8-inch diagonal black lines. Two black, block outline drawings of a cross (Illustration B), each on a separate piece of paper and facing a different direction. One cross is covered by crisscross lines 1/8-inch apart. The figures should be approximately 4 inches in size.[12]

Illustration A

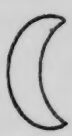


Illustration B

4. a. Show child moon and say, "What is this?" If child does not know, tell him. As the label is not important for this task, if the child labels picture differently, use his response. Say, "Put your finger on the moon and pretend to draw around it." Assist child until he can do task. Then say, "I am going to hide the moon." Present moon facing in different direction with 1/8-inch diagonal lines across it. Say, "Now, put your finger on the moon and draw around it."

b. Show child cross and say, "What is this?" Once again the label is not important for this task. Say, "Put your finger on the cross and pretend to draw around it." Assist child until he can do task. Then say, "I am going to hide the cross." Present cross facing in different direction with 1/8-inch crisscross lines on it. Say, "Now, put your finger on the cross and draw around it."

Note: Speed, eye-hand coordination, accuracy, distractibility or confusion due to lines.

Child receives one (1) point for tracing properly around the moon and one (1) point for tracing around the cross.

Materials: Two pictures with overlapping shapes – shapes are traced from puzzle pieces used in item number 1.

Picture No. 1

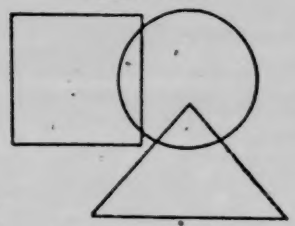


Illustration C

Picture No. 2

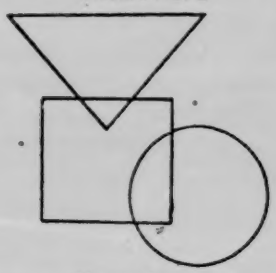


Illustration D

5. *Discrimination:* measures fine discrimination, part-whole relationships and visual closure.

   Materials: Five pictures of a little girl: complete, head missing, foot missing, arm missing, and mouth missing.

   (Developmental Learning Materials, Body Concept Ditto Masters)

6. *Number Concepts:* measures identification of objects, classification into groups and recognition of number relationships.

   Materials: one flannel board large enough to hold the following felt pieces: three (3) apples, three (3) circles, five (5) squares, and six (6) bunnies. Pieces are grouped in rows.

c. Present picture No. 1 and the round puzzle piece. Tell the child, "Place this piece on the one like it in the picture."

d. Present picture No. 2 and the square puzzle piece. Tell the child, "Put your finger on the one just like this." (show square) "Now draw around it."

Note: Accuracy, ease of completion.

Child receives one (1) point for placing circle puzzle piece directly on drawn circle, and one (1) point for tracing around the square shape.
Total: 4 points.

5. Present picture of girl with nothing missing, say, "This is a little girl." Present picture with head missing, say, "Here is the little girl again, but something is missing, put your finger on the part that is missing."

   Present picture with foot missing, say, "Put your finger on the part that is missing in this picture." Repeat the above instructions for the picture with the arm and mouth missing.

   Note: Accuracy of pointing vs. labeling, ease of response.

   Child receives one (1) point each for the identification of the body part that is missing.
   Total: 4 points.

6. a. Present flannelboard with pieces on it, each set grouped on separate lines, say as you point to each group, "What are these?" (Apples, circles, squares and bunnies)

   b. Hold out hand for felt pieces. Say, "Give me *one* (1) apple." "Give me two (2) circles." "Give me three (3) squares." "Give me five (5) bunnies." Wait for the child's response after each command.

   c. Hand child apple, say, "Put this apple on the board with the one just like it." Then give child the rest of the

	pieces that he has previously taken off, and say "Now put these back where they belong." Note: Speed of completion – make sure child hands you the amount that he wants. Child receives one (1) point each for correctly labeling the four flannel piece groups. Total: 4 points. Child receives one (1) point each for removing the correct number of pieces in each group. Total: 4 points. Child receives one (1) point each for placing the pieces back in their proper groups. Total: 4 points.

As the Fine Motor/Perception screening is administered, the examiner should note observations about the child's performance on the score sheet.

FINE MOTOR/PERCEPTION STATION

Total Points = 36 Points

CRITERIA FOR FOLLOW-UP

1. Twenty-eight (28) total points or lower on entire station.
2. Child demonstrates definite weakness in one or more of the sub-areas.
3. Child demonstrates complex pattern of weaknesses in several sub-areas.
4. Professional judgment.

FINE MOTOR/PERCEPTION STATION

DATE _____

NAME _____ No. _____ B.D. _____ SEX _____

1. Matching:

SHAPE	COLOR	SPEED	HANDS	MANIPULATION	COMMENTS
Square _____	_____	Slow _____	Both _____	Poor _____	
Circle _____	_____	Moderate _____	Left _____	Fair _____	
Rectangle _____	_____	Fast _____	Right _____	Good _____	
Triangle _____	_____				

2. Blocks:

	Structure Made	MANIPULATION
3 Pyramid Tower _____		Poor _____
6 Pyramid Tower _____		Fair _____
6 Blocks (2 steps) _____		Good _____
4 Blocks (Memory) _____		

3. Stringing Beads:

	SPEED	MANIPULATION
1 Bead _____	Slow _____	Poor _____
2 Beads _____	Moderate _____	Fair _____
3 Beads _____	Fast _____	Good _____
4 Beads _____		

PERCEPTION

4. Figure-Ground:

	IMMEDIATE	STUDIES*	NEEDS CUES
Moon 1 _____	_____	_____	_____
Cross 2 _____	_____	_____	_____
Circle 1 _____	_____	_____	_____
Square 2 _____	_____	_____	_____

5. Discrimination:

Head _____	_____	_____	_____
Foot _____	_____	_____	_____
Arm _____	_____	_____	_____
Mouth _____	_____	_____	_____

6. Number Concepts:

	LABELS	NO.	CLASSIFICATION
1 Apple _____	_____	_____	_____
2 Circles _____	_____	_____	_____
3 Squares _____	_____	_____	_____
5 Bunnies _____	_____	_____	_____

COMMENTS

Effort toward task	1 Won't quit	2 Works overly hard	3 Attentive	4 Works with constant reminding	5 So distracted can't do task
Self Confidence	1 Constantly seeks assurance	2 Eager to please	3 Assured	4 Mind of own	5 Refuses or says "No"
Social Interaction	1 Will not respond	2 Minimal responses	3 Cooperative	4 Aggressively sure	5 Hostile

Gross Motor/Perception Station

CHAPTER 6

The literature has shown that one rather reliable means of evaluating a child's development is to examine his motor skills. Pediatricians often refer to the acquiring of these different skills as "milestones", and use these stages of development as a guide to the "normalcy" in the development of the young child. From the physician's observation of the infant's head control, to the teacher's observation of the child's skipping technique, the gross muscle skills appear to develop along a continuum. By examining a child's ability relative to his age, and by comparing this ability to the tasks along the continuum, one can obtain another view of the child's over-all development.

Gross Motor skills, such as laterality, body image, rhythm and neuro-muscular differentiation play a definite role in perceptual-motor development. The way a child relates to environmental stimuli helps him to generalize his learning experiences. When perceptual experiences do not match motor experiences, the child becomes constantly confused by the two types of activity and the different picture of the outside world which they represent. It is obvious that the development of motor and visual perception abilities are important before the pre-school child enters kindergarten. Coordination of the child's body and his awareness of the surrounding environmental stimuli directly affect his success at school.

It is with this background in mind that the Gross Motor/Perception Area was created as part of the screening instrument. The entire screening at this station takes approximately eight to ten minutes and is administered by the Learning Development Specialist, or an individual with training in early childhood education.

GROSS MOTOR/PERCEPTION STATION

TASK	DIRECTIONS FOR ADMINISTRATION AND SCORING
1. *Balance Beam:* measures balance, body coordination and posture flexibility. *Materials:* 6-foot long balance beam, measuring 3½ inches wide and 4 inches high (from the ground).	1. a. Place child at beginning of balance beam, say, "Step up on this board and walk all the way to the other end." Examiner walks behind child observing. b. Then have child turn sideways and walk to the other end, stop and return. Do not let child turn body to start the return trip. c. At end of beam tell child to stop and then walk on the beam backwards. (Omit this step if child has had extreme difficulty balancing.) Note: Balance, posture, speed, stepping off, use of arms. Child receives three (3) points if he performs task easily; two (2) points if he pauses, steps off board more than once, if posture is stiff, but completes task; one (1) point if child cannot perform task, is unbalanced, or has

2. *Jumping:* measures laterality, body image, rhythm and muscular control.

   Materials: None needed.

3. *Identification of Body Parts:* measures knowledge of body parts and their positions as a prerequisite for development of space localization and perceptual motor skills.

   Body Parts: Head, Eyes, Ears, Mouth, Shoulders, Elbows, Hips/Waist, Feet, Knees.

   Materials: None needed.

obvious difficulty in coordination of body movements.

2. Examiner demonstrates, saying "Jump up like this." Examiner jumps up once keeping feet together. Examiner than jumps up on right foot once saying, "Jump up like this," touch right leg of child to indicate which foot he is to use if necessary. Repeat for left foot.

   Note: Control of body, ease of use of right and left foot, balance.

   Child receives three (3) points if he performs task easily; two (2) points if child has some trouble jumping, shifting of balance, or uses sides unequally, but completes task; one (1) point if child cannot jump, falls forward, or uses only one side of body.

3. a. *Identification Task:* Examiner says to child "Touch your head, touch your eyes, etc." Continue through nine body parts. (See if child can locate body parts on both sides of the body.)

   b. *Labeling Task:* Examiner says to child, as she touches her own body parts, "Tell me what this is called." Examiner touches all body parts as listed.

   Note: Hesitations, "feeling around," touching both parts simultaneously, ease of labeling.

   Child receives three (3) points for locating and labeling body parts easily; two (2) points if child hesitates, points only to one of the paired parts, but completes task; one (1) point if child cannot perform task, "feels around" body but cannot locate or label part.

4. *Imitation of Movement:* measures neuromuscular control and the translation of visual stimuli into a motor movement, body awareness.

   Movements:

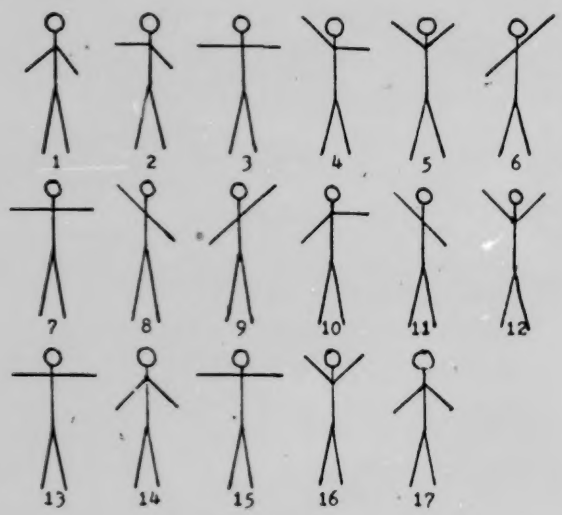


Illustration E

5. *Obstacle Course:* measures how child reacts spatially to environmental objects. Aids in determining to what extent a child's "clumsiness" is a spatial error or a motor control problem.

   Materials: One yardstick.

6. *Perceptual-Motor Activities:*[13] detects problems of directionality and perceptual-motor matching (ability to match motor performance with visual control), coordination of muscular flow through arm and shoulder to wrist and fingers (general use of body), preferred hand, accuracy and size of production, visual direction and attention, mid-line difficulty.

4. Examiner stands child two (2) feet in front of her, so that child faces examiner and has free arm movement. Say, "I am going to move my arms and I want you to move your arms just like I do." Examiner then moves through 17 arm positions in order, as listed, waiting for child's response at each position. Pre-school children will usually mirror the examiner's movements, rather than parallel them.

   Note: Confusion of arm movements, hesitations, abortive movements.

   Child receives three (3) points if he performs promptly and consistently; two (2) points if he shows hesitation of which arm to move and/or direction of arm movements; one (1) point if child exhibits incorrect movements without correction or shows complete confusion at task.

5. Hold yardstick in horizontal position against a wall about knee high for child. Say "Step *over* the stick." Hold yardstick about chest level for child and say, "Go *under* the stick." Hold yardstick far enough away from wall so child can slip through only by turning his body sideways, and say, "go *between* the stick and the wall." If necessary a hand motion may be given to aid the child in understanding the prepositions.

   Note: Bumping into stick, under-ducking, over-stepping. Child should perform task without physical aid, as holding on to wall.

   Child receives three (3) points if he performs task easily; two (2) points if he makes an error, as crawling under stick or bumping into it, but corrects easily in one repetition; one (1) point if child noticeably over- or under-estimates stick and cannot correct error.

6. a. *Circle:* Stand child at middle of chalk board, say "Pick up the chalk and draw a big, round circle." If child draws small and cramped circle, erase and ask child to draw a bigger circle.

   Note: If child moves hand in smooth movement especially as he crosses midline, twisting of body, hand use, closure, shape of circle, eye-hand coordination, any distortions in shape.

Materials: Chalk board that will not be too high for child. Two pieces of chalk.

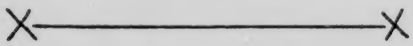


Illustration F

Illustration G

7. *Visual-Motor Memory:* measures ability to reconstruct motor patterns from primarily visual stimuli previously seen. (Audition is used as a secondary cue in this task.)

Materials: None needed.

b. *Horizontal line:* Ask child to close eyes. Place an X on one side of board and another X at opposite end about shoulder high for child. Child is told to open eyes. Examiner stands child at middle of chalkboard, between Xs and points to left X and runs finger across board to right X, while saying, "Pick up the chalk and draw a line across the board to connect the two Xs." Examiner may assist by placing child's hand with chalk on left X. (Illustration F)

Note: Hand used, if child shifts chalk from one hand to other, jerky movement at midline, twisting of body, straightness of line, any breaks in line, accuracy at touching Xs, hesitations.

c. *Vertical lines:* Have child close eyes. Place two Xs a foot apart just above child's head and two more Xs directly below (about one foot below) the top Xs. Child is told to open eyes. Examiner points to the four Xs, places child in middle of board, and says, "Pick up two pieces of chalk (make sure one in each hand) and draw two (2) lines connecting the top Xs and the bottom Xs." Examiner may assist child by placing both hands on upper Xs. (Illustration G)

Note: Straightness of lines, if parallel, if child showing preference for one hand, synchrony and weaving or bowing of lines, jerky movements, breaks in lines.

Child receives three (3) points for satisfactorily completing the three perceptual-motor activities; two (2) points if he completes two out of three; one (1) point if child demonstrates difficulty in all three tasks.

7. a. *Hand Pattern:* Examiner and child are standing. While child is watching, examiner claps hands at own waist, over head and again at waist. Examiner says, "Now you do just what I did."

Repeat demonstration if child does not wait and watch full demonstration. Task may be repeated once.

b. *Foot Pattern:* Examiner and child remain standing. While child is watching, examiner stamps the right foot once, then the left foot twice. Examiner then says, "Now you do just what I did." Task may be repeated once.

Note: Confusion in pattern, alternating task sequence.

Child receives three (3) points if he performs correctly all three positions of hands and feet and uses the correct timing; two (2) points if he claps or stamps only two out of three positions and/or has the correct timing but incorrect positions, or gets either the hand pattern or foot pattern correctly; one (1) point if he has incorrect timing and positions of hands or feet.

8. *Bean Bag Throwing and Catching:* measures eye-hand co-ordination and body movement. *Materials:* 3 differently colored bean bags and plastic bucket (or any container large enough to hold bean bags).	8. Child is standing approximately six (6) feet from examiner. Examiner tosses bean bage to child one at a time. Then child is asked to toss bean bags, one at a time into bucket held by examiner. (As different colored bean bags are used, the examiner often calls for bags by color, presenting the opportunity to evaluate if child knows color labels – do not score for color). Note: closing eyes when catching, using only one hand, no preparedness seen – as reaching for bag, accuracy of throwing, motor control. Child receives three (3) points if catches all three bags and can throw them into the bucket; two (2) points if child's accuracy is off or inconsistent in throwing and/or catching; one (1) point if child closes eyes, does not reach for bean bag or uses only one hand.

As the Gross Motor/Perception screening is administered, the examiner should note observations about the child's performance on the score sheet.

GROSS MOTOR/PERCEPTION STATION

Total Points = 24 points

CRITERIA FOR FOLLOW-UP

1. Eighteen*(18) total points or lower on entire station.
2. Child demonstrates definite weakness in one or more sub-areas, (scoring one point).
3. Child demonstrates a complex pattern of weaknesses in several sub-areas.
4. Professional judgment.

GROSS MOTOR/PERCEPTION STATION DATE _____

NAME _____ No. _____ B.D. _____ SEX _____

1. Balance Beam:

COMPLETES	STEPS OFF	MOVEMENT	COMMENTS
Forward _____	Few X's _____	Slow _____	
Sideways _____	Moderate _____	Moderate _____	
Backward _____	Frequently _____	Fast _____	

2. Jumping:

Both Feet _____ Left touches _____
Right _____ Left _____ Right touches _____

3. Identification of Body Parts:

TOUCHES	LABELS	HANDS
Head _____	_____	One only _____
Eyes _____	_____	Both _____
Ears _____	_____	Feels around _____
Mouth _____	_____	
Shoulders _____	_____	
Elbows _____	_____	
Hips/Waist _____	_____	
Feet _____	_____	
Knees _____	_____	

4. Imitation of Movement:

Mirrors _____ Frequent hesitation _____
Parallels _____ Marked confusion _____
Corrects errors _____ Loses attention – gets carried away _____

5. Obstacle Course:

Steps over _____ Overestimates _____
Steps under _____ Underestimates _____
Fits between _____ Steps on stick _____

6. Perceptual Motor Chalk-Board Activities: SHAPE SIZE DIRECTION

Circle _____ Poor ___ Lg. ___ Sml. ___ Clos _____
Horizontal _____ Lines wavey ___ Walks along board _____
Vertical _____ Lines bow in ___ out ___ poor synchrony _____
Hand used: right ___ left ___ both _____

7. Visual-Motor Memory:

Hand movement _____ Time not positions _____
Foot pattern _____ Positions not time _____
2 out of 3 positions _____

8. Bean Bag Catching:

1. _____ Closes eyes _____
2. _____ Uses one hand _____
3. _____ Tosses right ___ left _____
Aim off _____
Colors _____

COMMENTS

Effort toward task	1 Won't Quit	2 Works overly hard	3 Attentive	4 Works with constant reminding	5 So distracted can't do task
Self Confidence	1 Constantly seeks assurance	2 Eager to please	3 Assured	4 Mind of own	5 Refuses or says "No"
Social Interaction	1 Will not respond	2 Minimal responses	3 Cooperative	4 Aggressively sure	5 Hostile

Speech and Language Station

CHAPTER 7

The purpose of a simple screening for speech and language is to determine whether or not a particular child is communicating adequately for his age. If a child can communicate his thoughts intelligibly to a listener and can understand the communication of others, then it can be said that his speech and language performance is within normal limits for his age. A child's communication skills can usually be determined briefly by having him spontaneously discuss particular pictures or answer a set of questions with a trained listener. As the same pictures and questions are used for all children, a set of "informal" norms can be internalized by the Speech and Language Clinician and used as a means of comparison between children. Spontaneous speech is most important, in that it allows the examiner to hear what should be the child's normal communicative abilities and to simultaneously listen to and informally evaluate the child's articulation, language, fluency, and voice. Following the spontaneous or conversational speech, a set of pictures is presented for naming which allows the Clinician to evaluate the articulation of specific sounds. When sounds are misarticulated by the child, the Speech Clinician stimulates for these sounds – first in isolation and then in words. This involves the clinician being the model for the correct production of the sound, which the child is instructed to imitate. Research has shown that the ability to respond to stimulation may serve as a predictor of possible self-improvement in articulation[14] and has implications for follow-up. However, when problems emerge, further testing is presented to determine if the child is demonstrating difficulties in other areas, such as auditory perception areas – auditory memory, auditory discrimination, etc. This further information is then used to determine whether or not the child needs further in-depth diagnosis.

Such a screening procedure takes approximately five minutes; however, on particular borderline children, more time will be needed to administer the more in-depth speech and language screening tasks. This station should be administered by a trained Speech and Language Clinician.

SPEECH AND LANGUAGE STATION

TASK	DIRECTIONS FOR ADMINISTRATION AND SCORING
1. *Spontaneous Speech:* observation of child's normal, spontaneous expressive and receptive communicative abilities. Semantic and syntactic aspects of oral language are observed. Some syntactic elements include the use of various parts of speech, (i.e. nouns, verbs, adjectives, adverbs, conjunctions, etc.), structural complexity, mean length of sentence response, and the ability to make spontaneous corrections. Semantic development observed includes vocabulary, inner language, ability to describe actions and categorize them, and the ability to discuss a topic. *Materials:* Several pictures of high interest value for the pre-school child. A sequence of pictures with a story line is good for stimulating language.	1. Show child one of the pictures or a series of pictures, say, "Tell me a story about this picture." Very often more prompting is required so that a good sample of spontaneous speech is obtained. At this point any necessary cueing, or asking of questions is acceptable to encourage language. Note: Language, voice, articulation and fluency errors, according to the rating scale that follows this section. (Developmental Sentence Types are used as one criteria for evaluation.)[15] The child's performance is rated 1-5 according to the rating scale.

2. *Articulation Sample:* to determine if child's articulation is adequate for communication. Templin Darley Norms for the Development of Sounds are used.[16]

   Materials: Pictures eliciting words that contain an articulation sample: candle, feather, valentine, elephant, rabbit, bridge, thumb, scissors, squirrel, sandwich, zipper, shovel, flag.

**If no errors have been made up to this point, the Speech and Language Screening is completed. If, however, the child has made some errors, the rest of the test is administered.

2. As each picture is individually presented to the child, say "What is this?" If the child is unable to identify a picture, clues are given to elicit the proper response. If the label is not known the examiner may supply the word for the child.

   Note errors on score sheet.

   If a particular sound is misarticulated, try to have the child copy the correct production, first in isolation then in a word. For example, if the child says *tandi* for *candle*, note this and return to this word and sound following the last picture. Try to elicit the /k/ sound from the child, say, "Now listen carefully and watch my mouth – *k, k, k*, now you say it." Note if child says sound correctly. Then say, "Now listen carefully and watch my mouth again – *candle, candle, candle*, now you say it." Record the child's response. Stimulate for all misarticulated sounds as thoroughly as possible.

   Note: Generally, articulation errors of omission are most severe, followed by substitution and then distortion errors. If following stimulation, the child can correctly produce the sounds he originally misarticulated, this may be predictive of possible self-improvement. The research shows that this child's chances of self-correction are better than the child who could not be stimulated for the correct production.[17] The child's performance is rated 1-5 according to the rating scale.

   Throughout this portion of the screening, thus far, questions are asked about the pictures, or conversation is made by the examiner about various topics, as a means of sampling the child's understanding of language.

3. *Auditory Discrimination:* to determine if child can hear the difference between two similar-sounding words, testing the ability to differentiate cognates.

   Materials: Pictures of the following pairs: wing-ring, tree-three, coat-goat, sheep-jeep, dime-time, light-white, bear-pear, mail-nail.

3. Depending on the child's performance, all of the auditory discrimination pictures may be presented, or just the ones corresponding to the sounds misarticulated in the articulation sample. Show one card at a time to the child, say "Point to the picture that I name. Ready? Show me *wing*." Proceed through the cards, having the child point to the picture named. It does *not* matter which picture is named by the examiner; merely name one from each pair. Note the child's responses.

   Note: Child's ability to discriminate between two similar sounding sounds. The child who cannot make the discrimination has a more severe problem than the child who can. Failure to discriminate auditorally would give further indication for follow-up.

4. *Auditory Memory:* to determine ability to recall digits and sentences. (This portion of the screening is often administered to the child who exhibits weaknesses on the recall portions of the Cognition Screening).

   a. Digits: 6-4-1, 3-5-2, 8-3-7, 4-7-2-9, 3-8-5-2, 7-2-6-1.

4. a. Say, "I will say some numbers, then I want you to say them back to me. Ready? 6-4-1, etc."

b. Sentences: We are going to buy some candy. Jack likes to feed the little puppies. Jane wants to build a big castle in her playhouse.	b. Then say, "Now I will say some words, then I want you to say them back to me. Ready? We are going to buy some candy, etc." Record responses on score sheet. Note: A four to five year old child should be able to repeat 4 digits and the shortest sentence presented in the screening. A child of 4 years-6 months should remember the second longest sentence, and a child of five years, the longest sentence.[18]
5. *Following Directions:* to further evaluate child's receptive language and auditory memory skills, and child's understanding of prepositions (on, in, under, in front of, in back of). *Materials:* a small box and block.	5. Say, "I am going to tell you some things to do. Listen carefully and do what I say. Ready? Stand up, clap your hands, and point to your shoes." Next show the child the box and the block, say, "This is a block and a box. Now put the block in the box; now put the block on the box; now put the block under the box; now put the block in front of the box; now put the block in back of the box." Record child's response after each instruction. A four-year-old child should be able to complete all of the instructions without error.
6. *Physiologic Support For Speech:* to evaluate the oral structures necessary for correct speech production. *Materials:* Tongue depressors.	6. Look in child's mouth, examining the oral structures and functions, including velopharyngeal closure and diadochokinetic rate. Any physiological irregularities affecting the child's ability to communicate intelligibly should be further evaluated.
7. *Voice:* to evaluate various aspects of voice as quality, loudness, resonance and pitch.	7. Throughout the screening, observe the child's voice, by noting the quality, loudness, resonance, and pitch (as hoarseness, harshness, nasality, etc.). Child's performance receives a rating of 1-5 according to the rating scale.
8. *Fluency:* to evaluate fluency of speech.	8. Throughout the screening, observe the fluency of child's speech, noting any hesitations, prolongations and/or repetitions. Any tenseness or anxiety observed in speaking situations should also be noted. Child's performance receives a rating of 1-5 according to the rating scale.

As the Speech and Language Screening is administered, the examiner should note observations about the child's performance on the score sheet.

SPEECH AND LANGUAGE STATION

CRITERIA FOR FOLLOW-UP

No total score is received in the Speech and Language Screening. A child receiving a rating of 4 or 5 in any one or combination of the following areas, language, articulation, voice, or fluency, should be further evaluated by the Speech and Language Clinician. A child receiving a score of 3 in any of the areas would probably be placed in Wait and Watch and rescreened at a later date. Any child receiving a rating of 2, 3, 4, or 5, would automatically be rescreened by a District Speech and Language Clinician on entering kindergarten.

SPEECH AND LANGUAGE RATING SCALE

The Speech Rating Scale that follows was devised by the Speech Clinicians in District No. 65, to accompany the Speech and Language Screening as just described. It has provided consistency in rating children's speech and has aided in judging severity of speech disorders. The PECD Speech Clinician's use of this speech screening instrument and rating, has provided continuity in evaluating pre-school and elementary school children.

SPEECH RATING SCALE

Language Problems:

No. 5 Language is severely atypical for child's mental age and demonstrates a combination of differences in semantic and syntactic development.

No. 4 Problem is quantitatively and qualitatively less severe than No. 5, but still demonstrates more than one type of language problem.

No. 3 Less severe language difference but should be re-checked.

No. 2 Developmental and environmental language difference that is not hampering communication.

No. 1 No problem.

Articulation Problems:

No. 5 Multiple, severe articulation problems with intelligibility greatly impaired.

No. 4 Severe distortions and substitutions resulting in reduced intelligibility.

No. 3 Sufficient articulation difference to enroll if time is available, but intelligibility unaffected.

No. 2 Slight difference judged to be developmental or environmental. Intelligibility unaffected.

No. 1 No problem.

Voice Problems:

No. 5 The quality, loudness, resonance or pitch is deviant enough to call attention to itself.

No. 4 Some people may be aware of voice problem, but not all with whom child comes in contact are aware of the problem.

No. 3 Child suffers from some voice deviation, as hoarseness, but others are not aware of problem.

No. 2 Suffers from occasional or slight voice problem, as nasality or hoarseness.

No. 1 No problem.

Fluency Problems:

No. 5 Child exhibits hard blocks in stuttering and struggling behavior in speech.

No. 4 Indirect therapy indicated because child is unaware of his lack of fluency. Therapist will talk with parents and teachers.

No. 3 Demonstrates easy repetitions. May have been previously enrolled and is being rechecked periodically.

No. 2 Speech is easy flowing most of the time. Teacher and/or parent may be advised to keep speaking situations relaxed for this child.

No. 1 No problem.

SPEECH AND LANGUAGE STATION

DATE _____

NAME _____ No. _____ B.D. _____ SEX _____

ARTICULATION AND LANGUAGE:

1. Spontaneous Speech _____

2. Articulation Sample:

candle _____	elephant _____	thumb _____	sandwich _____
feather _____	rabbit _____	scissors _____	zipper _____
valentine _____	bridge _____	squirrel _____	shovel _____
			flag _____

STIMULATABILITY: Isolation * Word

3. Auditory Discrimination:

wing-ring _____	coat-goat _____	dime-time _____	bear-pear _____
tree-three _____	sheep-jeep _____	light-white _____	mail-nail _____

4. Auditory Memory:

DIGITS		SENTENCES
6–4–1 _____	4–7–2–9 _____	We are going to buy some candy.
3–5–2 _____	3–8–5–2 _____	Jack likes to feed the little puppies.
8–3–7 _____	7–2–6–1 _____	Jane wants to build a big castle in her play house.

5. Following Directions:

Stand up, clap your hands, point to your shoes _____ Put the block on the box _____, in the box _____, under the box _____, in front of the box _____, in back of the box _____.

6. Physiologic support for Speech:

STRUCTURE	FUNCTION
Lips _____	Lips _____
Teeth _____	Tongue _____
Tongue _____	_____
Hard Palate _____	VFH Closure _____
Soft Palate _____	Diado Rate _____
Tonsils _____	_____

VOICE:

1. Pitch _____ 3. Resonance _____ 5. Other _____
2. Loudness _____ 4. Quality _____

FLUENCY: _____

Comments:

Effort toward task	1 Won't quit	2 Works overly hard	3 Attentive	4 Works with constant reminding	5 So distracted can't do task
Self Confidence	1 Constantly seeks assurance	2 Eager to please	3 Assured	4 Mind of own	5 Refuses or says "No"
Social Interaction	1 Will not respond	2 Minimal responses	3 Cooperative	4 Aggressively sure	5 Hostile

Cognition Station

CHAPTER 8

The Cognition Station was designed to examine those skills that are deemed necessary for learning. The cognitive tasks used in the screening were selected according to the following criteria: (a) *Content Sampling* – measures several types of cognitive skills, namely, classification, symbol discrimination, rote memory, and several types of learning tasks (uncued recall, serial learning, and paired associate learning); (b) *Predictive Validity* – cognitive skills on which certain school-type tasks are theoretically based; (c) *Basic Ability Versus Experience* – a combination of tasks that differentiate between levels of "basic ability" and "applied ability." Tasks measuring basic ability have relatively low dependence on particular experiences or training, while those measuring applied ability have relatively greater dependence on relevant training or experience; and (d) *Materials* – concrete objects and pictures of familiar things (wherever possible to keep the materials relatively experience-free).

The Cognition Area has proven to be flexible; it can be administered as a separate station, or can be incorporated in the Speech and Language Station, Fine Motor/Perception Station and Gross Motor/Perception Station. Experience has demonstrated that Cognition is most beneficial to the overall screening when incorporated in the other stations. The child has one less station to visit and one less adult to meet and adjust to. On the following pages, the various tasks from the Cognition Area are designated to the stations in which they are administered. The division of the tasks have greatly aided the information obtained by the examiner at each station. For example, the task involving verbal responses are assigned to the Speech and Language area; thus providing the Speech Clinician with a larger sampling of speech. Likewise, if a child has exhibited language weaknesses, the Speech Clinician can adjust the administration of her particular cognition tasks to help elicit a response from the child. Another advantage is that by incorporating cognition, the other stations have become more equal in length and thus the flow of movement from one area to another has become smoother. It should be mentioned that at times it is more convenient and beneficial to administer this station separately; this is especially true when there are a large number of children to be screened at one time. (This often occurs when several children arrive late for appointments.) When this occurs, a trained Professional-in-Training administers the Cognition Instrument at a separate station. The administration of the Cognition Section in total requires approximately ten (10) minutes.

COGNITION STATION

TASK	DIRECTIONS FOR ADMINISTRATION AND SCORING
1. *Serial Learning:* basically a visual and auditory memory task for pictures. Serial learning implies that the child must remember the pictures in a particular sequence. *Materials:* Pictures of a bird, cat, bee (bug), and a dog. (When "cognition" is incorporated into other areas, this task is administered at the Fine Motor Station.)	1. Say, "I am going to show you how to play a game of hide and seek." Show animal picture cards. "Here are pictures of four animals." Put cards down one at a time on top of each other; try to elicit name of animal from child. However, if child does not know label, supply it for him. The order of presentation at this point is not important. Say, "Now they are all going to hide." Put cards face up in front of child and say, "The bird is going to hide here, the cat is going to hide here, the bee is going to hide here, and the dog is going to hide here." Let child look for four seconds and then turn them face down. Then say, "Point

to where the dog is hiding (position 4), point to where the cat is hiding (position 2), point to where the bird is hiding (position 1), point to where the bee is hiding (position 3)." Make sure child only points as a response; do not let him turn pictures over until the end.

The child receives one point for each correct response.
Total: 4 Points.

2. *Rote Counting:* measures ability to count to ten. Rote counting is essential for the eventual learning of number concepts. The child is also given an opportunity to count blocks.

   Materials: 10 blocks all the same color. (When Cognition is incorporated into other areas, this task is administered at the Fine Motor Station.)

2. Say, "(name), now I want you to count for me. Count to ten, you know, 1, 2, ..." If response is less than 3, probe further saying, "Good you have the idea. Try it again." Then say, "Good, now I want you to count these blocks for me." Place ten blocks before child. Help him to start counting if necessary.

   Child receives one (1) point for counting to four (4); two (2) points for counting to 5, 6, 7 or 8; three (3) points for counting to 9 or 10. This scoring also applies to counting objects: one (1) point counting four (4) objects; two (2) points counting up to eight (8) objects; three (3) points counting up to ten (10) objects.
   Total: 6 Points – 3 Points each.

3. *Free Recall for Objects:* measures ability to recall objects previously presented. This task involves visual and auditory memory skills.

   Materials: A box with a lid or cover, containing the following objects: spoon, gum, car, pencil, comb, and ball. (When Cognition is incorporated into other areas, this task is administered at the Gross Motor Station.)

3. Say, "Now I am going to show you some things in this box." Present box. "Look very carefully at everything in the box, and try to remember them." Name objects: spoon, gum, car, pencil, comb, and ball, at a one-second rate. "Look carefully and try to remember all of them." Close box and say, "Now tell me all of the things you saw in the box." Probe if necessary. Write order for each object recalled and any additional items that are named.

   Child receives one (1) point for each item remembered. The order in which a child remembers the objects has definite implications for learning; more specifically, for the child demonstrating a weakness, the order will provide an aid in developing a learning approach for use in remediation.
   Total: 6 Points.

4. *Recall for Words:* measures ability to recall words; this is basically a short-term auditory memory task. Once again the order of recall is important for learning. If a child exhibits a weakness on this task, it is recommended that the auditory memory task, digit and sentence memory, in the Speech and Language area be administered.

   Materials: None needed. (When Cognition is incorporated into other areas, this task is administered at the Speech and Language Station.)

4. Say, "Now I am going to say some words. You listen very carefully to each one and try to remember them." Say the trial words first, "boy, candy." Child repeats. Say, "boy, candy, chair." Child repeats. Make sure the child understands the task before proceeding. Say, "Good, now I am going to say a lot more, listen and try to remember them." Say words in given order at one (1) second rate: "milk, penny, baby, shoe, red, house." Next say, "Tell me all of the words you can remember." Once again, probe if necessary. Write the order in which words were recalled. Write any added words, often times a child will mention a word from recall of objects. Proceed with Trial 2, say at a one (1) second rate: "red, baby, milk, shoe, house, penny."

   A point is given for each correct word recalled.
   The child receives two scores, one for each trial.
   Total: 12 Points.

5. *Symbol Discrimination:* ten nonsense symbols were selected for same-different comparison with an identical or transformed symbol.[19] The ability to discriminate between symbols that look similar is important for learning to read. When errors are made, the type of error should be observed, as rotation-reversal or break and closure; this information should be used in planning a program of remediation for the child.

Materials: Twelve (12) cards (5"x8") with the following pairs on them. The first three (3) are trainer cards. (When Cognition is incorporated into other areas, this task is administered at the Gross Motor Station.)

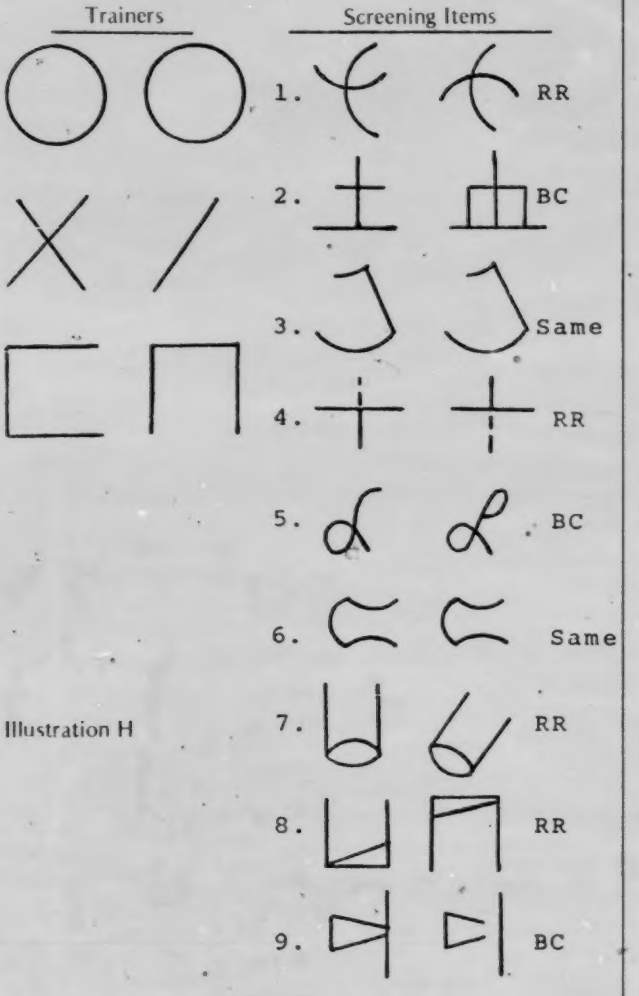


Illustration H

5. Say, "Now I am going to show you some pictures. Some will look exactly alike or the same, and some will not look alike, they will look a little different." Present training cards one at a time. "Look at these pictures, (point to 0 and 0), do they look exactly alike?" Encourage an affirmative response. Next point to X and /. "Do they look just alike or the same." If correct, say good and ask to explain. If incorrect, say, "Look again, they look different or not alike, because one goes like this (trace X) and has two lines that cross, and one goes like this (trace /) and has only one line. They do not look alike." Present the third trial (C and Ↄ). "Do these look just alike?" If child is incorrect, explain reversal, using tracing as an aid. Most importantly, use terminology that the child understands. The goal is to examine the child's ability at recognizing if two symbols are the same or different, not to test his knowledge of terms. So use any combination of "alike, not alike, same or different, etc." Present test cards in given order, unpaced, asking each time if they look the same or different-alike or not alike. DO NOT correct mistakes for the test cards. When a child responds that two symbols are not alike, it is helpful to ask the child why. This will give more indication as to whether the child is guessing or actually has the concept. Circle the child's responses, S or D, note if child can give reason why symbols are different.

The child receives one point for each correct response.
Total: 9 Points.

6. *Visual Sequential Memory:* measures child's ability to recall pictures in a particular order. This task utilizes visual cueing only. The Visual Sequential Memory task, along with Serial Learning, Recall for Objects and Recall for Words, have important implications for understanding how

6. Present the pictures of the apple and the banana, in that order, in front of the child. Say, "Here are two pictures, this one goes here (point to apple) and this one goes here (point to banana)." Then say, "Now I am going to mix them up and I want you to remember that this one goes

a child learns. More specifically, these tasks help to indicate the child's best modality for learning, through auditory or visual channels.

Materials: Picture of an apple, banana, grapes and orange. (Pictures from Peabody Language Development Kit, Level No. P, American Guidance Service.) (When Cognition is incorporated into other areas, this task is administered at the Speech and Language Station.)

7. *Paired-Associate Learning:* measures child's ability to remember items that are associated in some way. By examining the child's performance, the actual matching, one can attempt to speculate about the child's competence, the reasoning behind the matching.

Materials: Three (3) boxes are needed: two divided into four compartments with lids, one with no dividers and no lid. Box 1 (Paired Associate Box) has two paired objects in each compartment. Box 2 (Paired Associate Test Box) contains only one of the pair, the stimulus, in each compartment. Box 3 (Response Box) is a flat, undivided box containing all response items, unattached, plus one extra item, a toy car. The items should be spaced as follows: block, car, scissors, ball, crayon.

	ASSOCIATION	STIMULUS	RESPONSE
1.	(color)	balloon	crayon
2.	(rhyming)	clock	block
3.	(use)	knife	scissors
4.	(shape)	marble	ball
			toy car (extra)

1	2
3	4

(When Cognition is incorporated into other areas, this task is administered in the Fine Motor Station.)

here (point to apple) and this one goes here (point to banana)." Be sure not to name the pictures! Examiner mixes pictures, and then gives child both pictures and says, "Now put them back just the way they were."

b. Remove pictures, then present the pictures of the banana, grapes and apple, in that order, in front of the child and say, "Here are three pictures, this one goes here (point to banana), this one goes here (point to grapes), and this one goes here (point to apple)." Then say, "Now I am going to mix them up. I want you to remember that this one goes here (point to banana), this one goes here (point to grapes) and this one goes here (point to apple)." Examiner mixes pictures, and then gives child all three pictures and says, "Now put them back just the way they were."

c. Proceed with task presenting the following four pictures in this order; grapes, apple, orange, banana, using the above directions. Write the order on the score sheet in which pictures were sequenced.

Child receives one (1) point for correctly sequencing each group.
Total: 3 Points.

7. Say, "(Name), now I am going to show you a game where things stay together, like special friends." Present Box 1, Paired Associate Box. "You watch very carefully and try to remember what things go together." Open first compartment and say "The balloon and crayon go together because they are the same color." Close, and open next compartment, say "The clock and block go together because they sound alike." Close, and open next compartment and say, "The knife and scissors go together because they both cut." Close and open last compartment, say "The marble and ball go together because they are both round." Then present Box 2 (Test Box) and Box 3 (Response Box). Open the first compartment in Box 2 and present the first stimulus, the balloon. Say, "What goes with the balloon, find its special friend in this box." (Point to Box 3.) After the child selects an item, *place it back in* Box 3, in its proper space. Child should always be selecting from five (5) items. Proceed through the remaining three compartments in Box 2 the same way. Check the pairs the child picks correctly.

The child receives one (1) point for each correct response.
Total: 4 Points.

8. *Classification:* measures the ability to group items according to an established criteria; purpose is to evaluate if the child can group items and give the reason for grouping.

   Materials: Separate pictures of shoe, shirt, guitar; ball, circle, glass of milk; comb, red balloon, red fire engine; hamburger, cake, telephone; dog, bicycle, cat. (Pictures from Peabody Language Development Kit, Level No. P, American Guidance Service.) (When Cognition is incorporated into other areas, this task is administered in the Speech and Language Station.)

8. Present and name training cards, the pictures of the shoe, shirt and guitar. Say, "Here are three pictures, two of them are alike in some way, and one does not belong. Point to the two that go together best." After child responds, ask, "Why do they go together?" If child is incorrect in his reasoning, or even if he is correct, elaborate on all of the ways that the two pictures (shoe and shirt) can go together, as color, size, use, etc. Present and name the following four sets of cards, one set at a time, and ask, "What two pictures go together and why?"

   Child receives one (1) point for each correct choice and one (1) point for each correct reason. Many times a child will give the wrong choice, but give a good reason for his choice. In such a case, he would get (0) points for choice and one (1) point for reason. The opposite may also hold true, a child may make the right choice, but not be able to explain why, in which case he would get a point for choice, not for reason. If the child makes the wrong choice, you may show him the correct choice and try to elicit the reason. If he can verbalize the reason, he receives one (1) point for reason only, (0) points for choice.
   Total: 4 points for choice; 4 points for reason.

If Cognition is administered as a separate station, the examiner should note observations about the child's performance on the score sheet.

Each child is allotted three scores according to his performance on the Cognitive tasks; a "Basic Ability Score" or *B Score*, an "Applied Ability Score" or *A Score* and a *Total Score*. The *B Score* measures a more basic level of ability as it is more culture-free relative to tasks and task materials, previous training and experience with related tasks, or the child's willingness to verbalize. By contrast, the *A Score* is more dependent on previously acquired skills. The *A Score* also includes interdeveloping stages of discrimination and classification skills. The Cognitive tasks contributing to the two subscores are summarized below:

B SCORE (BASIC ABILITY). 26 POINTS

Task No.	Skill	Points
1	Serial Learning	4
3	Recall of Objects	6
5	Symbol Discrimination	
	Same	2
	Break & Closure	3
6	Visual Sequential Memory	3
7	Paired Associate Learning	4
8	Classification	
	Choice	4

A SCORE (APPLIED ABILITY) — 26 POINTS

Task No.	Skill	Points
2	Rote Counting	3
	Counting Blocks	3
4	Recall for Words	12
5	Symbol Discrimination Rotation and/or Reversal	4
8	Classification Reason	4

Total Points: 52 Points

COGNITION STATION
CRITERIA FOR FOLLOW-UP

1. Twenty-eight (28) total points or lower on entire station.

2. Discrepancy between B Score and A Score, with B higher than A. Average B Score (13 or more) and low A Score (less than 10).

3. Child demonstrates average total score, but exhibits definite weakness in one or more sub-areas.

4. Child demonstrates a complex pattern of weaknesses in several sub-areas.

5. Professional judgment.

COGNITION STATION

DATE _____

NAME _____ No. _____ B.D. _____ SEX _____

BASIC SCORE _____
SERIAL LEARNING _____
RECALL FOR OBJECTS _____
SYMBOL DISCRIMINATION
SAME _____
BREAK & CLOSURE _____
VISUAL SEQUENT. MEM. _____
PAIRED ASSOCIATE LRNG. _____
CLASSIFICATION _____
CHOICE _____

APPLIED SCORE _____ TOTAL _____
ROTE COUNTING _____
BLOCK COUNTING _____
RECALL FOR WORDS _____
SYMBOL DISCRIMINATION
ROTE & REV. _____
CLASSIFICATION
REASON _____

1. Serial Learning (*Check if correct*)

_____ 3 bird
_____ 2 cat
_____ 4 bee
_____ 1 dog

2. A. Rote Counting (*Circle highest correct*)

0 – 1 2 3 4 – 5 6 7 8 – 9 10
0 1 2 3 pts.

B. Counting Objects

0 – 1 2 3 4 – 5 6 7 8 – 9 10
0 1 2 3 pts.

3. Free Recall for Objects (*Write order in which remembered*)

_____ spoon
_____ gum
_____ car
_____ pencil
_____ comb
_____ ball

4. Free Recall for Words (*Write order in which remembered*)

_____ milk Trial 1
_____ penny
_____ baby
_____ shoe
_____ red
_____ house
_____ red Trial 2
_____ baby
_____ milk
_____ shoe
_____ house
_____ penny

COMMENTS

5. Symbol Discrimination (*Circle Response; correct one is underlined*)

Symbol		Response		Discrim. type
	1.	S	D	RR
	2.	S	D	BC
	3.	S	D	Same
	4.	S	D	RR
	5.	S	D	BC
	6.	S	D	Same
	7.	S	D	RR
	8.	S	D	RR
	9.	S	D	BC

6. Visual Sequential Memory (*Write order in which sequenced*) SCORE

apple ___ banana ___ _____
banana ___ grapes ___ apple ___ _____
grapes ___ apple ___ orange ___ banana ___ _____

7. Paired Associate Learning (*Check correct pairs*).

	S	R
_____	balloon	crayon
_____	clock	block
_____	knife	scissors
_____	marble	ball

8. Classification Skill (*Check if correct choice; check if correct reason*)

CHOICE	REASON	
_____	_____	shape
_____	_____	color
_____	_____	food
_____	_____	animals

Screening Staffing

CHAPTER 9

Following each day's screening (Thursday and Friday), the PECD Screening Staff meets to discuss the performance of each child who participated in the screening on that particular day. Each staff member brings to the Screening Staffing the scores sheets in numerical order (according to the child's identification number) for all of the children screened at her station. One staff member acts as coordinator for organizing the clerical aspect of the staffing. The procedure for each child is as follows.

The Coordinator reads the first child's name and number and completes the identifying information on the top portion of the Screening Summary Form (Appendix A). She then separately names each screening area; the staff member who administered that portion of the screening elaborates on the strengths and weaknesses of the child's performance in the area. Depending upon the criteria for the particular screening area, the child's performance is either judged as having been performed satisfactorily or as having demonstrated a weakness. In the Vision and Hearing areas, the performance is simply judged and designated "pass" or "fail." These results are noted on the Screening Summary Form in their appropriate place. If weaknesses were exhibited, they are briefly outlined here. The Coordinator collects all score sheets for each child and staples them together with the Screening Summary Form on top. This package constitutes a child's file.

During the Screening Staffing the status of the child is determined; it can be anyone of the following: (1) Pass, (2) Follow-up, or (3) Wait and Watch. Those children designated as "Pass" have performed satisfactorily on all of the screening areas; they have demonstrated no weaknesses and the PECD staff and the parents have no concerns about the child's development. These "Pass" files are kept alphabetically in a locked cabinet. The parents of these children are notified through a letter (Appendix B) that their child has performed satisfactorily on the screening. Generally no additional contact is made with these children or their families. However, at any time, the detailed screening results may be obtained by the parent, or the pre-school teacher with parental consent. The following September, the child's screening results, presented in terms of relative strengths, are disseminated to the child's kindergarten teacher. (This aspect of the program will be discussed in detail in the final section of the book.)

The "Follow-up" category is for children who need to be contacted following the initial screening. The reason for the contact may be that (1) the children demonstrated a weakness or weaknesses in one or more screening areas, (2) the parent has a concern that needs to be discussed with a PECD staff member. The Criteria for Follow-up, as discussed at the conclusion of procedures for administration and scoring for each station, are used to determine whether a child will be placed in this category. Often a child will perform satisfactorily on the various screening items, but will demonstrate some type of behavior for which the staff wants to obtain further information. Or possibly, the child performs satisfactorily, but the Child Behavior Profile shows deviations that need to be further evaluated. In such instances the child would be placed in the Follow-up category. Follow-up cases are kept alphabetically in a locked cabinet.

The "Wait and Watch" category is for those children who either demonstrated a minor weakness, had difficulty completing the task, or for any reason had to terminate the screening, as due to illness, immaturity, etc. These children are usually young, below 3 years 6 months. "Wait and Watch" primarily means that for some reason, as mentioned, this child had difficulty with the screening, making the results invalid and requiring that the child be screened again at a later date. This category is often utilized for the young child (below 3 years 6 months) who participates in the screening, but for whom the tasks are developmentally too difficult; this child's file would be placed in Wait and Watch and he would be given another attempt on the screening prior to his entering school. Wait and Watch is also often

used for a child that was in Follow-up, has received recommendations for work at home, and needs to be rescreened at a later date. The staff uses Wait and Watch as a means of monitoring or keeping track of the young child who needs to be rescreened or reevaluated. A locked cabinet is designated for these cases as well.

During the Screening Staffing, a Professional-in-Training is simultaneously recording the summary information on a Screening Record Form (Appendix C). This is done to insure accuracy in record keeping and to provide a means of summarizing the information obtained on *all* of the children participating in the screening. Next to each child's name and other identifying information, the Professional-in-Training notes if the child "passed", "failed" or was "untestable" in the Hearing and Vision screening areas, and also records if the child's performance in each of the other areas was satisfactory or not. Finally, the Case Status (Pass, Follow-up or Wait and Watch) is noted, plus the Staff Member assigned to the case. This information is primarily used for administrative purposes and like all other information regarding the individual child, is kept in a locked cabinet.

FOLLOW-UP AND WAIT AND WATCH PROCEDURES

If a child is placed in the Follow-up or Wait and Watch category the following procedures are implemented at the Screening Staffing. During the discussion of the child's screening performance, the child's major area of weakness should emerge. This will determine to which staff member the child will be assigned. For example, a child with a hearing or vision problem would be assigned to the Nurse; a speech problem, to the Speech and Language Clinician; a learning problem, to either the Educational Therapist or Learning Development Specialist, and a social-emotional problem, to the Psychologist. The guidelines for this assignment are flexible. For instance, if a child exhibits weaknesses at a particular station, as Gross Motor, then he would probably be assigned to the specialist in that area. If a complex pattern of weaknesses is observed in the various screening areas, then through discussion it would be determined which staff member would be assigned to the child. In making these assignments, consideration is given to each staff member's case load. The purpose of having one staff member assigned to each child is to insure individualized treatment for the child and family. Using this model, the parent and child will have one PECD staff member with which to communicate, and intervention, even if it involves several disciplines, will be coordinated by one person.

On receiving the Follow-up or Wait and Watch case assignment, the staff member fills out a Face Sheet (Appendix D) for the child's file; this includes identifying information, plus the status of the case. This page is attached to the front of the other forms (Screening Summary Form and Score Sheets). It contains useful information that will be used frequently and therefore, needs to be easily assessible. In addition a Contact Form (Appendix E) is attached to the back of the file. This sheet is necessary for the recording of *all* contacts made concerning the child. The staff member making the contact, notes the date of the contact, to whom the contact was made, what information was exchanged, and then initials the remarks so that it will be known and recorded who made the contact from PECD. Any other relevant information concerning the child, as diagnostic testing, therapy schedule, etc., should be recorded here. This information must be reported as completely and accurately as possible.

To insure accurate record keeping, and to expedite administrative/supervisory tasks, an index card is completed for each child in either the Follow-up or Wait and Watch category. The index cards are color coded, as the score sheets, corresponding to the PECD Professional Staff Member and her Station or Screening Area. On examining the index cards at a glance, one can determine a particular staff member's case load and can easily select all of those cases for which she is responsible. The card system also allows the staff to find out particular information about a Follow-up or Wait and Watch child without having to go through large and rather cumbersome case files. This method of record keeping is essential for keeping track of the large number of children which the staff contacts.

During the Screening Staffing, the staff member assigned to the child, will complete her corresponding color index card with the following information regarding the child. (Appendix F.)

1. Child's Name and Identification Number
2. Birthdate
3. Sex
4. Address and Telephone Number
5. Screening Date
6. Pre-School Program (if any)
7. Staff Member responsible for Child
8. Statement of Problem

The record of Follow-up should be recorded below this basic information. This refers to *any* contacts made concerning the child, whether it be by phone, letter or visitation. As in the child's file, the information should include the date the contact was made, to whom the contact was made (parent, guardian, teacher, etc.), by whom (PECD Professional Staff Member or Professional-in-Training), and the *basic* informa-

tion that was exchanged. As in the file, any information relevant to the case is noted here, such as the date for diagnostic evaluation, therapy site and schedule, rescreening date for Wait and Watch, etc. The information on the card should be stated briefly; it is basically a synopsis of the information contained in the child's file. Both sides of the card should be used and when the card is filled, another is started and attached to the original.

All index cards are stored in a three-drawer file box; they remain in the file box and are only removed to make an entry. The three drawers are for the (1) Follow-up cases, (2) Wait and Watch cases, and (3) Follow-up Completed cases. The cards are arranged alphabetically. A child's card remains in Follow-up or Wait and Watch until intervention is completed; the card is then transferred to Follow-up Completed.

Following the Screening Staffing, the PECD staff members are responsible for contacting the parents of those children assigned to them, with information regarding the child's screening performance and future plans or recommendations. Some type of contact for ALL children in Follow-up and Wait and Watch must be made and recorded. This contact is preferably made by phone or in person; however, this is often impossible, in which case a letter would be sent by the PECD staff member. (Appendix G.) Much of the success of the operation is dependent upon the prompt contact made with the parent and the accurate completion of the cards and files in relation to this contact and all others. The Monthly Summary Report (Appendix H) which is completed by each professional staff member, provides a brief summary of the intervention status of Follow-up and Wait and Watch cases.

Often the Screening Staffing procedure is time consuming; however, the individualized attention given to each child has proven to be important in reporting strengths and weaknesses and in minimizing the likelihood of children being "labeled" at this early stage in their educational development. Further, this model exemplifies a philosophy that has the potential for bringing about changes in the schools to better meet the needs and strengths of all children in the community as they enter the school system.

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PART THREE:

DIAGNOSIS

General Attributes of Diagnosis

CHAPTER 10

The Screening Instrument for Evaluating Developmental Skills (SIEDS) is utilized to generally, yet methodically, determine a child's strengths and weaknesses. It is important to reiterate that the term "screening", as used here, implies a general separation of skills. If a child exhibits a moderate to severe weakness in one area, or a complex pattern of weaknesses in several areas, based on the screening criteria, it becomes necessary to conduct further evaluation "to obtain sufficient information to determine whether there is a problem, the nature and severity of the observed disorder, and recommendations for therapy, referrals, or counseling."[1] The PECD staff seeks to obtain an accurate picture of the child as well as a comprehensive and detailed description of the child's weakness. The diagnostic evaluation can be either formal or informal, depending upon the child and the nature of the problem.

FORMAL DIAGNOSIS

The formal diagnosis involves requesting that the parent and child come to the PECD Learning Center on a particular day or days and participating in an interview, observation and actual examination. The goals of a formal diagnostic evaluation are three-fold. (1) History Taking—by means of interviewing the parent, the staff attempts to discover past status of the child, facts about onset or early development of the problem, which may help determine the etiology and prognosis. (2) Clinical Observation and Examination — by observing the child, and the child and parent in various situations, the staff can begin to formulate ideas about the problem, if it does in fact exist, the handicapping nature of it, the severity, etc. To further understand the child and the nature of the weakness, formal diagnostic testing, utilizing standardized instruments, is attempted. (3) Recommendations — by collecting all of the available data on the child and evaluating his performances on various tests, the staff can begin to suggest a prognosis and make appropriate recommendations for remediation and hopefully, amelioration of the problem. It is this process of formal data gathering, utilizing standardized tests, that identifies specific tasks the child can or can not do, that allows the staff to plan a remedial program that is designed to supplement the child's weaknesses by utilizing his strengths.

The procedures for a formal diagnostic evaluation are as follows: Based on the screening criteria and professional judgment, a diagnostic evaluation may be recommended for a particular child at the screening staffing. The staff member assigned to the child, as discussed in the previous chapter, will determine, based on the child's screening performance, which areas (Speech and Language; Learning Readiness-Cognition, Fine Motor, Gross Motor, Perception; Social-Emotional, Vision and Hearing) will be evaluated. This will in turn determine which staff members will participate in the evaluation; they comprise the diagnostic team. The staff member assigned to the case during the initial staffing is designated the captain; she in turn is responsible for all organization of the diagnostic procedures. All information as discussed and agreed upon at the Screening Staffing, should be recorded on the child's index card and on the Screening Summary Sheet.

Friday afternoons are designated for diagnostic evaluations. Depending upon the nature of the diagnostics, two may be scheduled per afternoon. The staff member responsible for the case, the captain, contacts the parent as soon after the Screening Staffing as possible; the results of the screening are explained along with PECD's desire to do more in-depth testing. A calendar for diagnostic evaluations is kept in the PECD Learning Center; when the staff member makes the contact with the parent, she schedules an appointment for the diagnostic evaluation and records this on the calendar. (This same information should also be noted in the child's file and on his index card.) During the week prior to the diagnostic evaluation, there is a staffing consisting of the diagnostic team (captain and other staff members participating in the evaluation), to decide where the child's major

weaknesses lie and to determine which tests should be administered and by whom. It is the captain's responsibility to ensure that the testing forms and materials are available and in order for the Friday appointment.

The parent brings his child to the PECD Learning Center. If time permits, the parent and child remain together shortly; this gives the staff an opportunity to observe the interaction between the parent and child. The parent is then taken to an adjoining room where he/she is interviewed by the PECD Nurse and possibly, Psychologist. During the interview the case history is obtained (Appendix I) and possibly the Vineland Social Maturity Scale or the Pre-school Attainment Record is administered. If PECD requests to receive additional information about the child from another source, or if the parent wishes that PECD information be forwarded to another source, then the consent form for release of information is signed at this time by the parent (Appendix J.)

While the interview is being conducted, the child is being tested in a separate room by the appropriate PECD staff members. As soon as a test has been administered, the results are immediately evaluated and compared to the normative data for that test. If at all possible, a staffing will be held immediately following the administration of all of the tests and a statement of diagnosis made, along with recommendations for intervention. In some cases this will not be possible, due to the complexity of the case. If it is not possible to complete the staffing while the parent and child wait, then another appointment is made by the team captain with the parent to discuss the results and the recommendations. The captain is responsible for collecting all diagnostic data, for explaining the results and recommendations to the parent, and for writing an examination report. The report should contain information regarding (1) the initial complaint or referral, (2) history information, (3) examination results, (4) statement of diagnosis or summary, and (5) recommendations. With the parent's consent, a copy of the examination report is routinely sent to the child's pediatrician. A brief statement of diagnosis should be entered on the child's index card along with a brief statement of the recommendations (i.e., severe articulation disorder, enrolled in individual therapy Mondays and Wednesdays, 9:00–10:00, at PECD Learning Center to begin on September 17, 1973). All children receiving diagnostic evaluations have their own folder, kept in the Follow-up file. This folder contains screening forms, all diagnostic test scores sheets and forms, consent forms and two copies of the examination report.

INFORMAL DIAGNOSIS

In caring for the child exhibiting weaknesses, it is the responsibility of the PECD staff to determine what specific symptoms are present, what conditions determine them and what can be done to ameliorate them. Helmer Myklebust refers to the diagnostic problem as "differential diagnosis." Before a diagnosis is made and remediation can be attempted, "the condition must be differentiated from others which may produce the common symptom."[2] That is to say, a symptom, as no expressive language, must not be assumed to be caused by one condition, as poor hearing acuity. The symptom must be examined from every possible angle; it must be determined which of various conditions is causing the disorder. Probably the most efficient way of obtaining such information is through formal diagnostic testing. Unfortunately it is not always possible or practical for a formal evaluation to be administered to every child exhibiting weaknesses on the screening. One such reason preventing formal diagnosis, is the inappropriateness of a test for a particular child. Simply, the child may not be functioning at a level necessary for the completion of the test, or the child may not be able to willingly attend to the test, or the test may not be geared to meet the child's needs. Considering the child and the nature of the problem, it may be decided that diagnostic information can *best* be obtained during therapy.

This approach to "differential diagnosis" is hereafter referred to as diagnostic therapy. Essentially it implies performing diagnostic type tasks during the actual therapy session. A careful examination of the screening results will give an indication of the level of functioning of the child. Further the results should begin to illustrate the areas that present the most difficulty for the child. It is from this point that the diagnosis begins; the clinician must begin to ascertain which tasks the child can and cannot perform. During the first several weeks of therapy, the staff presents activities, starting at that level where the child has success, and proceeding with tasks which become increasingly more difficult, until it can be determined where the child is functioning. As the sessions progress, this kind of "trial and error" approach begins to yield an accurate picture of the child's skills. Although formal test scores are not available on the child, the staff still has learned the specific tasks the child can and cannot do. With such complete information on record, a statement of diagnosis can be made, along with recommendations for remediation.

The importance of diagnosis, whether it be formal or informal, lies not in the eventual labeling of a problem, but in the detailed description of the child's strengths – his successes, and weaknesses – his failures. The diagnostic evaluation is merely a tool for identifying particular skills and locating that point where the child no longer has success in performing designated tasks. If such a point is below what it should be for the age of the child, then the evaulation can

provide the necessary information for designing a remedial program, which will hopefully raise the child's level of success. The following pages describe in more detail the diagnostic aspect of the Program in Early Childhood Development. Primarily the description includes information regarding formal diagnosis in Social-Emotional, Vision and Hearing, Learning (Fine Motor, Gross Motor, and Cognition) and Speech and Language development.

Social-Emotional Area

CHAPTER 11

Children and families who are to be re-contacted for follow-up by the PECD Psychologist are primarily identified in two ways. Children who obtain unusually high or low scores on the Behavior Profile filled out by the parents fall into this category. Also children whom the staff identify as exhibiting unusual behavior during the screening; this might be indicated on the Screener Checklist as the child who showed unusually hostile, withdrawn, worried, negative, or inattentive behavior. In spite of these attempts to carefully screen the children in a quick but accurate manner, many problem areas or concerns of the parent will not show up. It is therefore, essential to include an offer for the parent to see the Psychologist, without having to identify ahead of time the things with which they are concerned. To accomplish this, a simple question has been included on the information sheet completed by the parent: "Would you like an appointment to see the Psychologist?" It should be noted, that the parents request to see the Psychologist may involve a variety of problems not directly related (at first glance) to the pre-school child, but which inevitably will affect that child, and therefore should be responded to with some manner of follow-up.

The first contact after identification through the Behavior Profile, by staff observations, or at the request of the parent, is most efficiently made by phone whenever this is possible. During this initial contact a brief summary of the total screening results are given. At this point the parent may say that she has no concerns about her child or that she does not wish to be involved in any further evaluation or intervention. For the parent who may possibly be avoiding an unpleasant situation by denying a concern, the Psychologist will counsel her within the spirit of making psychotherapeutic help available, if not now, sometime in the future. It seems most important to clearly state the concerns, but also to respect the parental decision. This type of attitude also applies to cases where the major source of concern does not come from the screening data, but rather from the pre-school or other concerned persons. This might be approached in the following manner by the Psychologist: "This is what other people are concerned about and I was just re-contacting you to see if you shared these concerns." There have been few parents who have felt attacked or resentful of this form of concern.

Follow-up appointments by the Psychologist may be with the entire family, the parent(s), with the parent and pre-school child. With children three to five, it is often difficult to meet for long periods of time and be able to talk with the parents if the children are present. If the children are not present, then the ability to see more clearly the interaction between the parent and the child is lost. It may be necessary, therefore, even when no further formal testing is involved, to meet twice, once with just the parents and once with the child present also. Whether the child is seen, or just the parent, depends on the follow-up plan. If a diagnostic report is the goal, or if the emotional dynamics are unclear, then the child may be given further testing. It is felt by the PECD Psychologist that a careful diagnostic *interview* itself, will usually give the same kind of data as testing, and proves to be more helpful in establishing a working relationship with parents. The diagnostic interview should be therapeutic for the family as well as a time for collecting data for a diagnostic picture. The PECD staff for the most part has been more concerned with intervention at the Social-Emotional level than with lengthy diagnostic reports which may bias the treatment a child receives from his school or other agencies. This is especially true at an age where a child's behavior changes so rapidly, and at an age where a small amount of intervention with parents may often alter the situation and problem drastically. With this in mind, the diagnostic-therapeutic interview has been utilized considerably.

Two adjunct processes to the diagnostic-therapeutic interview are the Developmental History (Appendix I) and an interview with the pre-school teacher where the child is enrolled in a pre-school or day care center. The Developmental History is particularly important in formulating the

diagnostic picture, especially where there may be significant unanswered questions regarding learning problems, developmental lags, or physical questions. Information concerning any prenatal or post-natal injury, infantile behavior, and physical patterns of the child are particularly important in trying to determine how much of the present behavior is due to basically physical causes and how much is due to emotional factors in the family. If this Developmental History indicates severe developmental lags or injuries, the child may be referred for further neurological testing. With severe neurological involvement ruled out, the diagnostic and intervention planning can continue, concentrating on the learning and emotional problems and their interaction. In addition, the kind of information available from day care persons or pre-school personnel is vitally important. A visit to observe the child in this setting is often the most enlightening kind of information available diagnostically. This information can be compared with the information received from the parents about how they perceive the child. The child may act quite differently outside the home than in it. These kinds of observations can be discussed with the parents to help them begin to think about the various meanings of their child's behavior.

Additional and traditional psychological testing may be done by the diagnostic staff or referred out to other sources. Where intervention is as central a concern as testing and diagnosing (that is, where really helping children and families is the central concern, as opposed to passing out labels) staff priorities may mean that time be allocated more to talking with parents and children about their family dynamics. Further testing, if absolutely needed, can be done somewhere else on a referral basis. A few sessions with a mental health professional who can give the family a thorough understanding of the interaction of the dynamics of their own family and situation is certainly more valuable than a testing report which may be unintelligible to the family and unfortunately, sometimes not made available to them. It is therefore the philosophy of this program to use the diagnostic session or sessions as a first stage in intervention.

Vision and Hearing Area

CHAPTER 12

The Vision and Hearing area functions somewhat differently than the others in that the diagnostic and intervention stages of the child services component are combined into one step, consisting mainly of the medical referral. The following discussion describes the procedures utilized by the PECD Nurse when following-up on children failing the initial Vision and/or Hearing Screening.

VISION

The parent is contacted when the child fails the first Vision Screening. At this time, the PECD screening results are discussed and recommendations made for a second vision screening. The parent is also given instructions for teaching the child how to respond to the screening "game." An appointment is made at this time for a second screening with the PECD Nurse, or a referral is made to the Evanston North Shore Health Department (ENSHD) clinic or a private medical source, depending upon the parent's desire.

If a child seems able to see, but cannot perform on the screening, he will be placed in a Wait and Watch category with recommendations for a rescreen in three (3) to six (6) months. Instructions for "playing the game" will be emphasized to teach the vision screening technique.

For a child who apparently understands, but who does not respond as expected, a referral is made for a complete eye examination. If the parent agrees with the recommendation, a vision referral form will be given to the parent for the eye doctor to complete. If the parent does not recontact the PECD Nurse, or the Vision Reference Form is not returned in four (4) to six (6) weeks, the parent will be recontacted by phone or letter.

If the concern is confirmed, the vision problem diagnosed and treated and the vision report completed and returned, the teacher for the Visually Handicapped in the District can be contacted for additional educational recommendations to be given to the parent and/or to the child's pre-school teacher. The parent will be contacted again to see if any assistance of any kind is needed to carry out the physician's or the educator's recommendations and to encourage continuation of care.

HEARING

The parent is contacted when a child fails the first hearing screening to recommend a second screening. At this time, results of the total PECD screening are discussed with the parent as well as alternatives for the second Hearing Screening. It is suggested that an appointment be made with the PECD Nurse, the Evanston North Shore Health Department (ENSHD) clinic, or a private medical source.

If the second screening with the PECD Nurse is not successful the following steps will be taken:

1. A Threshold Test is immediately given. If referral criteria are met, the child is referred to his medical source, usually the pediatrician, and to the District Special Education Department. A copy of the audiogram and an otological report is given to the parent for the doctor. If there is no response from the parent, or the otological report is not received in four (4) to six (6) weeks by the PECD Nurse, then the parent will be recontacted by phone or letter. If the concern is confirmed and the problem diagnosed and treated and the report received, the District teacher for the Hearing impaired can be contacted for further educational recommendations for the parent and/or the child's pre-school teacher. The parent will be contacted again to see if assistance of any kind is needed to implement the doctor's or educator's recommendations, and to encourage complete follow through.

2. For those children who are not able to respond success-

fully to the Threshold Testing, recommendations will be made for testing again. If the test results continue to be unreliable, a referral will be made as described above.

The results of all children screened will be given to their respective school nurses and identified as passed, treated or under care.

Learning Areas

CHAPTER 13

PECD experience has shown that there appears to be considerable overlap in the areas of Gross Motor/Perception, Fine Motor/Perception and Cognition in terms of developmental skills and weaknesses. Very few children have exhibited an isolated problem in one of these areas; this refers to a moderate to severe weakness, which would require in-depth evaluation. (Mild weaknesses have emerged in a specific area; this type of situation will be described in the intervention portion of the book.) Based on the follow-up criteria, when a child does exhibit a moderate to severe weakness on any one of or any combination of the following areas, Gross Motor/Perception, Fine Motor/Perception, and Cognition, he then becomes a candidate for more in-depth evaluation. As described previously, the staff will determine the child's main area of weakness as observed on the screening. Using this information, tests are selected which will provide more detailed information concerning the problem. The following outline presents the various areas of evaluation and the tests used to measure the child's performance in these areas. Once again it is important to remember that the tests are selected on the basis of the child and his performance on the screening.

I. Learning Readiness Skills

A. Gross Motor
   1. Assessing balance, body coordination, body image and spatial relationships
      a. Lincoln-Oseretsky Motor Development Scale, W. C. Sloan, C. H. Stoelting Co., Chicago, Illinois, 1948-56.
      b. Southern California Motor Accuracy Test, A. Jean Ayres, Western Psychological Services, Los Angeles, California, 1964.

B. Perception – Difficulty in the Fine Motor, Gross Motor and Cognition areas of the screening may be a manifestation of an underlying perception problem. (See also Auditory Perception in the Speech and Language section)
   1. Assessing visual and visual-motor perception
      a. Developmental Test of Visual Perception, Marianne Frostig, Consulting Psychologists Press, Palo Alto, California, 1964.
      b. Developmental Test of Visual-Motor Integration, Keith E. Berry, Norman A. Buktenica, Follett Publishing Co., Chicago, Illinois, 1967.
      c. Southern California Perceptual Motor Tests, A. Jean Ayres, Western Psychological Corporation, Los Angeles, California, 1972.
      d. Southern California Figure Ground Visual Perception Test, A. Jean Ayres, Western Psychological Corporation, Los Angeles, California.
      e. The Purdue Perceptual Motor Survey, Eugene G. Roach, Newell C. Kephart, Charles E. Merrill Publishing Co., Columbus, Ohio, 1966.
      f. Illinois Test of Psycholinguistic Abilities, Subtests – Visual Sequential Memory, Visual Motor Association, Visual Reception, Visual Closure, Samual A. Kirk, James J. McCarthy, Winifred D. Kirk, University of Illinois Press, Urbana, Illinois, 1968.
      g. Goodenough-Harris Drawing Test, F. L. Goodenough, D. B. Harris, Harcourt, Brace & World Publishing Co., Chicago, Illinois, 1963.

The importance of diagnostic evaluation is to further delineate the child's strengths and weaknesses. The tests mentioned are utilized for this descriptive purpose. Needless to say, the list is not exhaustive, but only a sample of the devices now available.

Speech and Language Area

CHAPTER 14

As the PECD Speech and Language screening is primarily the same as the District No. 65 Speech and Language screening, so too are the diagnostic procedures similar. This correlation provides a continuity of services and record keeping at the pre-school and elementary school level. When a child enrolls in kindergarten in the District, information regarding the child's speech and language level can be easily disseminated to the appropriate school clinician. She can then readminister the Speech and Language Diagnostic Tests and determine the child's present level of functioning, as compared to his level of performance when first seen by the PECD Speech Clinician.

After screening, if a child is only being evaluated in the areas of Speech and Language, an appointment will be made by the Speech Clinician to have the parents or guardian bring the child to the testing center. While the child is being evaluated, the parent will be completing a speech case history form (Appendix K). The PECD Nurse is also available to obtain a more complete health and social history information and to administer the Vineland Social Maturity Scale and possibly, the Mecham Verbal Language Development Scale.

The four main areas of evaluation are language, articulation, voice and fluency. They will be briefly described, and the tests used to measure the child's performance in each of these areas indicated.

I. Language

A. Receptive Language – the child's understanding of oral language
   1. Assessing the comprehension of single words.
      a. Peabody Picture Vocabulary Test, Lloyd M. Dunn, American Guidance Service, Circle Pines, Minnesota, 1959.
      b. Assessment of Children's Language Comprehension (ACLC), Carol R. Foster, Jane J. Giddan, Joel Stark, Consulting Psychologists Press, Palo Alto, California, 1969.
   2. Assessing syntax and morphology
      a. Northwestern Syntax Screening Tests (receptive portion), Laura L. Lee. Northwestern University Press, Evanston, Illinois, 1969.
      b. Assessment of Children's Language Comprehension (ACLC)
   3. Assessing basic understanding, as following directions
      a. Oral Commissions Subtest of the Detroit Test of Learning Aptitude, Harry Baker, Bernice Leland, Public School Publishing Co., Bobbs-Merrill, Inc., Indianapolis, Indiana.
      b. Gesell's Action Agent Test, Harper & Brother, New York, 1940.

B. Inner Language – the child's sub-vocal symbol system, which involves the integration of information
   1. Assessing concept development, inner language, relationship of elements
      a. No formal test devised – this area is evaluated by observing the child at play with various toys – as doll house, doll furniture, etc.
      b. Illinois Test of Psycholinguistic Abilities (ITPA), Subtest Manual Expression, Samuel A. Kirk, James J. McCarthy, Winifred D. Kirk

C. Expressive Language – the child's speaking ability
   1. Assessing amount of output and adequacy of vocabulary
      a. Mean Length of Response
      b. Mean of Five Longest Responses
      c. Structural Complexity Score
      (The above are reviewed in *Diagnostic Methods of Speech Pathology*, Johnson, Wendell, Darley, Federic, and Spriestersbach, D. C., Harper and Row, 1963.)
   2. Assessing appropriate use of syntax and morphology

a. Northwestern Syntax Screening Test (expressive portion)
b. Developmental Sentence Types, Developmental Sentence Scoring, Laura L. Lee, Northwestern University, Evanston, Illinois.

II. Articulation – the production of speech sounds and their blending into words

A. Assessing child's production of speech sounds
1. Goldman-Fristoe Test of Articulation, Ronald Goldman, Macalyne Fristoe, American Guidance Service, Circle Pines, Minnesota, 1969.
2. Templin-Darley Tests of Articulation, Mildred, C. Templin, Frederic L. Darley, Bureau of Educational Research and Services.
3. A Screening Deep Test of Articulation, Eugene T. McDonald, Stanwix House, Inc.
4. Fisher-Logemann Test of Articulation, H. B. Fisher, J. A. Logemann, Houghton-Mifflin Co., Chicago, Illinois.

B. Assessing physiological support for speech – structures and their function
1. Peroral Evaluation – e.g. tongue structure and function, lip structure and function, velum structure and function, etc.

C. Assessing auditory memory

D. Assessing auditory discrimination (to be described under separate area – auditory perception.)

III. Fluency – the rhythm of speech

A. Assessing the child's rhythm of speech
1. Sample of spontaneous speech
a. Evaluated in terms of normal disfluencies, child's attitude toward speech, nature of disfluency pattern, parents' attitude towards speech of child

B. Assessing child's word recall ability
1. Evaluated by presenting individual pictures in rapid succession

C. Assessing receptive language
1. As described above

D. Assessing oral structures and function
1. As described above

IV. Voice – the pitch, rate, quality and volume of speech

A. Assessing voice
1. Sample of spontaneous speech
a. Evaluated in terms of pitch, rate, quality and volume

B. Assessing basis for problem (organic vs. non organic)
1. Medical background reviewed
2. Physiological support for speech (structures & functions)
3. Possible referral for laryngeal examination to Otolaryngologists

Necessary for the normal development of speech and language are adequate skills in auditory perception. This is being listed as a separate category only for organizational purposes. The areas listed under auditory perception would be evaluated in case of a possible language or articulation disorder.

V. Auditory Perception

A. Assessing auditory discrimination
1. Wepman Auditory Discrimination Test, Joseph Wepman, Language Research Associates, Chicago, Illinois, 1958.
2. Goldman-Fristoe-Woodcock Test of Auditory Discrimination, Ronald Goldman, Macalyne Fristoe, Richard Woodcock, American Guidance Service, Circle Pines, Minnesota, 1970.

B. Assessing auditory memory
1. Evaluation of Auditory Memory Span for Digits
2. Evaluation of Sentence Repetition
3. ITPA – Auditory Sequential Memory Subtest

C. Assessing auditory closure
1. ITPA – Auditory Closure Subtest

All tests administered have normative data for children as young as 3.0 years. The child's performance will then be compared to the normative data and recommendations made accordingly. This is by no means an exhaustive list of diagnostic tests in the area of speech and language. It is meant rather to illustrate what tests are available in the various areas of evaluation.

REFERENCES

[1] Sanders, Lois Joan. *Procedure Guides for Evaluation of Speech and Language Disorders in Children.* Urbana, Illinois: Stenographic Bureau, 1969, 1.
[2] Myklebust, Helmer R. *Auditory Disorders in Children.* New York: Grune and Statton, 1954, 3.

PART FOUR:

INTERVENTION

Intervention Model

CHAPTER 15

The identification of weaknesses in pre-schoolers only has merit in terms of the intervention that is provided following the identification. W. Wolfensberger noted that:

"Early diagnosis is desirable when it leads to prevention, early treatment, or constructive counseling; it is irrevelant if it is purely academic and does not change the course of events; it is harmful if, in balance, child or family reap more disadvantages than benefits."[1]

It is with this in mind that the PECD staff has worked toward developing and providing a practical, yet comprehensive intervention program.

The intervention phase of the program consists of three alternatives depending upon the child and the nature and severity of the weaknesses exhibited on the screening. The criteria for deciding which type of intervention is recommended for a child will be outlined below, but the final decision is primarily based on professional judgment as discussed with the parent.

1. Recommendations for parents and teachers:

If during the initial screening the child demonstrates a mild weakness in one or more of the areas, as a slight awkwardness on the balance beam, or slow, but accurate fine motor manipulation, it may be recommended that work be done with the child at home or in the pre-school. In such an instance a formal diagnostic evaluation would not be done. These recommendations come in the form of activity packets for the parent and/or pre-school teacher. The packets were compiled by the PECD staff from various sources and contain activities for the following areas of development: Gross Motor, Fine Motor, Cognition and Language. When the appropriate staff member contacts the parent to report the screening results, she will also discuss the possibility of the parent working with the child on the demonstrated low areas. If such a plan is acceptable to the parent, then the use of the appropriate activities will be explained and the packet mailed or personally delivered to the family. The activities are selected to build on the child's strengths in order to supplement the weaknesses.

It is the responsibility of the PECD staff member to recontact the parent and child within four to six months to evaluate the progress being made and to offer additional activities if necessary, or if requested by the parent. The strength of this aspect of the program lies in the continued communication with the family. If the child is in a pre-school program, similar activities are made available to the teacher so that there is some coordination of services being provided for the child; this of course is only done with the consent of the parent. If it is observed that a number of children in one pre-school or day care center demonstrated the same or similar weaknesses, then PECD will make recommendations or provide an in-service to the school for improving their curriculum in that area.

It is recommended that these children, although exhibiting only minor weaknesses, be rescreened just prior to entering kindergarten, so that the most recent performance might be disseminated to the kindergarten teacher.

The following intervention procedures are primarily directed to the children with more moderate to severe weaknesses as exhibited on SIEDS. The second and third forms of intervention occur chronologically after the PECD staff has attempted an in-depth evaluation and has made some statement of diagnosis.

2. Referral to a community agency for treatment:

If a child's needs, as outlined by the diagnostic evaluation cannot be met by the PECD staff and can better be served by a community agency, then the child is referred accordingly.

Evanston is a community with numerous resources in various areas of early childhood development. As a result of a concentrated effort to create a good working relationship with these agencies, the Program in Early Childhood Development now has numerous resources available and can insure appropriate services for pre-school children. Building such a rapport is primarily the result of cooperation from the agencies represented on the PECD Community Advisory Council, and each PECD staff member's personal contact with those agencies, programs, clinics, etc. that are most closely related to their discipline.

Several circumstances can result in referral to a community agency. For example, the child demonstrating a severe disorder, with recommendations for a concentrated, long term therapy program would probably be referred to an appropriate agency. Often the PECD Psychologist recommends a therapy program for the entire family when a pre-school child is diagnosed as having a social-emotional problem. Several of the social agencies in Evanston are far better equipped than PECD to provide such intervention services, thus a referral would be most appropriate. If the PECD staff is aware of a program either within the school district, as the District's special developmental pre-school programs, or the community, that seems to meet a particular child's needs, referral would probably be recommended to the parent. Very often services provided by an agency can supplement services offered by the PECD staff. An example of this would be the child receiving programmed language therapy from the Northwestern University Speech Clinic in addition to the therapy provided by the PECD Speech Clinician. Referring a family to a school or community agency is done only after careful consideration and discussion with the parent. Of primary importance is serving the child and family, and therefore every available resource is considered when a weakness is apparent and intervention recommended.

To insure coordination between the Program in Early Childhood Development and the agency to which a particular family is being referred, a Referral Form (Appendix L) is utilized. When contact between the agency and family has been made, and if the family has consented (Appendix J), then PECD screening and diagnostic information is exchanged.

It is important to mention that although community resources are primarily utilized for long term therapy, they are also available for consultation and further in-depth diagnostic evaluation. When it is necessary to obtain more information about a child before intervention recommendations can be pursued, this line of referral may be utilized. Medical referrals may originate at this point in time. This might consist, for example, of a referral to an Otolaryngologist by the Speech Clinician for a laryngeal or velopharyngeal examination in regards to a voice problem, or to a Pediatric Neurologist for a neurological examination.

To insure having a workable school-community program, not only has every effort been made to utilize the available resources in Evanston but also to acquaint these clinics, agencies, programs, etc., with PECD services for their possible use as a referral source. The goal then is to have a two-sided relationship, utilizing each others' resources so that in the end the Evanston family is benefiting from the school and community.

3. Enrollment in therapy:

Following the completion of the screening and diagnostic phase of the program for a child, the PECD staff member assigned to the case will prepare a written intervention prescription (Appendix M). This prescription delineates the child's major areas of strength and weakness, and the long term goals and objectives. This remains in the child's file and is updated periodically. The purpose of such a prescription is to help determine exactly which type of program will best meet the child's needs and to provide the staff with a realistic view of the child's level of functioning and to provide a framework in which a therapy program can be designed.

The PECD staff has developed an intervention model around two basic types of therapy programs.

Individual and Small Group Therapy

Individual and small group therapy is scheduled for Monday, Tuesday and Wednesday morning. The therapy is primarily held at the PECD Learning Center; however, as the staff is responsible for *all* pre-school children in the District, several staff members provide therapy at the children's pre-school site. For example, the Speech Clinician visits the District's Pre-School Developmental Classrooms and provides speech services. If it is recommended that a child be enrolled in therapy at the Learning Center, but arrangements cannot be made to bring the child, then if at all possible, the child will receive treatment at his day care center or nursery school.

Children enrolled in individual or small group therapy usually have the more severe problems and need a concentrated and structured program. Treatment may be recommended for any one or combination of the screening areas, Speech, Cognition, Fine Motor, Gross Motor and Social-Emotional. The staff attempts to work on a one-to-one basis with these children, and when necessary, as in the small groups, utilize the services of the Professionals-in-Training. Again one staff

member is responsible for a particular child, but if the child has weaknesses in more than one area, he may see other staff members during therapy, or one teacher can provide all therapy while getting consultation from another professional on the staff. Children seen in small groups are usually diagnosed as having similar or related weaknesses, making the groups more or less homogenous. It is possible to have in the Learning Center at one time, a group therapy session plus an individual session, or any combination of the two. Scheduling is obviously contingent upon the particular children being enrolled and the type and severity of the problems they exhibit. It is the goal to provide a concentrated, personalized therapy program.

Prior to the therapy session, a lesson plan is prepared for each child (Appendix N); it includes objectives for the day, activities selected to accomplish these objectives, and comments corresponding to the activities. Every child enrolled in a therapy program has a folder containing all lesson plans. This is very helpful for insuring an individualized instructional program and for documenting progress.

Generally the parent accompanies the child to the therapy session and this provides an excellent opportunity for the parent to participate in the actual session or for observing. The staff tries to incorporate the parent as much as possible in the intervention program and especially in regards to follow-up activities at home. Most children receive small assignments to complete between sessions. Having the full cooperation and support of the parent obviously insures better carry-over from the therapy session to the home. So too is the child's pre-school teacher notified of the therapy sessions, the goals, etc., so that she might further coordinate her classroom activities with the PECD staff. Of primary importance is providing a multidimensional therapy program, so that inervention will be complete.

Multidisciplinary Group Therapy

Multidisciplinary Group Therapy is scheduled for Monday, Tuesday and Wednesday afternoons from 1:00 – 2:30. This therapy is held at the PECD Learning Center; the room is divided into three areas, Speech and Language, Fine Motor, and Gross Motor (Cognition being incorporated in the three). The Speech Clinician, Educational Therapist and Learning Development Specialist remain at their appropriate areas the first forty-five minutes of the session. Approximately ten children participate in the therapy during each session. On entering the room they are divided into three smaller groups, and each group assigned to a particular area. The children remain in this area for approximately fifteen minutes and then rotate. Professionals-in-Training move with the children, to provide a constant adult for the children and to help the Professional staff member at each area. Using this format then, the children receive therapy in the various disciplines. The last fifteen minutes is designated for free play or for a large group activity.

Children selected for this type of program can operate in a setting where various activities are being conducted. These children primarily have weaknesses in more than one area, although not necessarily in all of the areas. Since the children participate at all of the stations, and are exposed to a variety of activities, they have the opportunity to demonstrate their strengths as well, important for the self concept of the child. Some children assigned to this therapy program need the opportunity to improve their socialization skills, which this setting provides. Recommendations from the Psychologist in the area of Social-Emotional growth, becomes an integral part of the multidiscliplinary intervention.

Prior to the session, the staff meets and prepares the lesson plan (Appendix O). One major concept is selected for the day and each discipline is responsible for attempting to teach that concept. This is more easily explained using an example. The general concept to be emphasized during the session is number concepts, one, two and three. This may be approached in the Gross Motor area by having the children jump and roll a ball one, two and three times, etc. In Fine Motor, the children may string beads and stack blocks, and at the Speech and Language area, they may use the felt board and tell a story involving three children. The important aspect of this model is that different approaches are used to teach and reinforce the same concept. The lesson plan (Appendix O) illustrates this. Note that each discipline is responsible for delineating the objective as related to the common concept and for selecting activities that will emphasize the objective. Observations concerning the appropriateness and success of the activities are noted on this lesson plan form. In addition to the information thus far described, each staff member is responsible for noting anything of importance concerning individual children which is to be emphasized or observed during the lesson. For example, if a particular child is low on language skills and the Speech Clinician wants the other staff members to urge the child to use a particular syntactical structure, then this would be noted on the lesson plan. So too, are strengths of each child noted so that they may be utilized to supplement the weaknesses during the therapy. Once again in accordance with the PECD philosophy, an individualized instructional program is insured. Following the therapy session, the staff discusses each child's performance in the various areas. Observations are noted (Appendix P), as is progress and recommendations for the next session.

During the multidisciplinary group therapy sessions, the

PECD Nurse conducts parent involvement sessions for those parents who desire and are able to participate. They spend the hour discussing relevant topics of their choice, developing instructional materials, having seminars with PECD staff and other community resource personnel. Under the direction of the Nurse, the parents participate in the actual therapy sessions; this has been most helpful in providing feedback about the goals and objectives of therapy, how they are accomplished, and what progress is being made. Not only does this provide the parents an opportunity to observe their children, but also encourages their involvement in program development and planning.

Additional Parent Involvement

Parent involvement at this level of the program was so successful that other means for including the parents were solicited. The PECD Nurse and Psychologist have thus arranged another parent group which provides an opportunity for any parent of a pre-schooler to join a one and a half hour evening session once a week for six weeks. The parents are asked to indicate at the initial screening their possible interest in such a program (Appendix Q). The group is open, in that parents of children who either performed satisfactorily or demonstrated weaknesses on the screening are invited to participate.

The group is designed so that the parents may select their own program format; they have the opportunity to arrange for speakers from the school system or community, and discuss relevant topics of interest. More specifically, during the past year (1972), one group dealt with understanding the needs and behavior of children. This was done primarily by helping the parents understand first their own behavior and needs, and secondly the past and current family patterns which help produce different roles for family members. The thrust of this group was toward helping the parents re-experience their own childhood feelings and roles, and applying this toward understanding their present family structure and children's needs.

The Program in Early Childhood Development encourages parent involvement at every level of the program. As it is a school-community program, it is important that parents have the opportunity to contribute to program planning and implementation.

REFERENCES

[1] Wolfsenberger, W. Diagnosis Diagnosed. *Journal of Mental Subnormality*, 1965, 11, 62-70.

PART FIVE:

DISSEMINATION

Dissemination of Information

CHAPTER 16

PECD information about each child who participated in the screening is disseminated to the District when the child enters kindergarten. For the child who performed satisfactorily on the initial screening, the information is forwarded to the kindergarten teacher in the form of a computer print-out of the child's relative strengths as exhibited on the SIEDS (Appendix R).

When a child is enrolled in therapy, ongoing evaluation is conducted. Rescreening is attempted at six-month intervals whenever possible. During the summer every effort is made to rescreen children who are enrolled or who had been enrolled in a therapy program, so that the most recent performance of the child is obtained. At the time of the rescreening, whenever it is conducted, a Progress Report is written (Appendix S). This report is the basis of information used in preparing the Narrative Profile (Appendix T) which is forwarded to the District when the child enters kindergarten, along with his computer print-out of relative strengths.

The Program in Early Childhood Development attempts to prepare the child for school, as well as prepare the school for the child. For this reason both the strengths and weaknesses of children seen by PECD are reported to the kindergarten teachers and special services personnel. The information is presented in a variety of ways; it should be mentioned again that no information is forwarded to the District without parental consent.

I. Kindergarten teachers directly receive information on their children, who were screened by the Program in Early Childhood Development. An appointment is made during the spring to arrange for a meeting the first week in September, between each kindergarten teacher and a PECD staff member. During this meeting the teacher receives a computer print-out of relative strengths on each child in her room who participated in the PECD Screening (Appendix R).

The purpose of these computer profiles is to provide kindergarten teachers the opportunity of fitting their instructional programs to the specific strengths and weaknesses of the individual students. Toward that end, the profile presents the following information:

1. A listing, in order of the child's performance, of the subtests included in the screening instrument, sections dealing with Gross Motor, Fine Motor and Cognition skills.

2. Following each subtest listing, a listing of the number of items correct, out of the total items on that section. Example: 6/10 indicates the child gave six correct responses out of a total of ten possible.

3. Also following each subtest listing, a standardized "T-Score" which reflects the child's performance relative to the total population of children screened. (These scores have a mean of 50 and a standard deviation of 10.)

4. An individual profile list is printed before the subtest designation. This score reflects the student's performance on each completed section of the screening relative to this overall performance. (The values are computed by finding the mean of the individual's T-Score on all the items then dividing each T-Score's value by that mean and multiplying by fifty. This gives a distribution with a mean of fifty so that the student's average performances on the screening sections will have values close to fifty.

5. Finally, a written conclusion is printed. A listing of up to four "strengths" and up to four "weaknesses" is printed. In order to restrict the listing of areas to those which are significantly different from the average performance of the student, no areas are listed where the score on the profile is less than two standard deviations away from the mean for that student.

Parts 4 and 5 of the profiles should be of the most interest and utility in the planning of individualized instruction.

In addition, the month and year of the screening are printed so that the results can be considered in terms of the learning which may have taken place since the screening. In cases of partial or total rescreening, the date listed reflects the most recent screening of that child.

The teacher also receives a Narrative Written Profile on those children who received some type of follow-up by the PECD staff (Appendix T). This report includes a summary of screening results, diagnostic information, a summary of the implemented intervention, progress noted and staff recommendations. The progress report, as referred to above, provides the basis for this information. During this meeting it is decided which children should be discussed at the local school In-Take meetings. This decision is based in part on the child's weakness and/or the status of PECD intervention at the time the child entered school. A list of these children is sent to the District Chief Social Worker, who in turn forwards the names to the appropriate principals to arrange for the In-Take meetings. It is during the school's In-Take meeting that various teachers and staff members have the opportunity to meet and discuss children for whom there are concerns.

II. Based upon a PECD staff decision, certain social-emotional cases are sent directly to the District's Chief Social Worker, who forwards them to the appropriate District 65 personnel. The PECD Psychologist consults personally with the Chief Social Worker about these cases. A report of these cases is presented in a Narrative Written Profile.

III. Vision and Hearing Screening results are forwarded to the individual School Nurse by the PECD Nurse. This consists of a computerized list of results for each child seen by PECD and/or the Evanston North Shore Health Department (ENSHD). The results are indicated as either Pass or Fail in the area of Vision and Hearing. For children who required follow-up in the area of Vision and Hearing, the school Nurse receives a status report in the form of an index card, (Appendix U). The kindergarten teacher also receives a copy of this form of dissemination.

IV. The Speech and Language information is given directly to District No. 65 Speech Clinicians by the PECD Speech Clinician. The District Clinicians receive a computerized list of all children performing satisfactorily on the Speech screening; this contains a ranking for each sub area (articulation, language, voice and fluency) according to the Speech and Language rating sheet, page 36. For each child exhibiting weaknesses, a Narrative Written Profile will be disseminated to the District Clinicians, with a copy to the child's kindergarten teacher. This report contains information regarding screening, diagnostic evaluation results, intervention, progress in treatment, and recommendations. These children are also considered for In-take depending on the nature of their problems.

One copy of the PECD Profile is kept at the PECD office. The kindergarten teacher receives a copy of all of the PECD profiles discussed during the September meeting. These profiles are *not* to be placed in the child's cumulative folder and will be labeled accordingly. The principal of each school will receive a list containing the names of all children at their school seen by the Program in Early Childhood Development.

Dissemination of information to the school district, the last step of the PECD procedural model, further illustrates the program's philosophy, that the school system shall meet the needs of *all* of the children.

By making every effort to forward complete information to the kindergarten teacher and special services personnel, a continuity of services between the pre-school and kindergarten is insured. The PECD staff feels very strongly that each child brings to school strengths that need to be recognized and utilized by the school system, and particularly the kindergarten teachers. So not only can the kindergarten teacher continue working on the child's weakness as identified by PECD, but she can implement her instructional program to build on the child's strengths. Implementing this philosophy hopefully will insure that children will be entering the school system with an equal chance of having a successful kindergarten year and educational experience.

APPENDICES

Appendix A

SCREENING SUMMARY

DATE _____

NAME _____ No. _____ B.D. _____ SEX _____

SCREENING AREAS:

Vision
Hearing
Speech and Language
Cognition
Gross Motor
Fine Motor
Social Emotional

RECOMMENDATIONS:

_____ Rescreen
_____ Diagnose
_____ Contact parent/teacher – no intervention, child is already enrolled in therapy
_____ Contact parent
_____ Contact teacher with recommendations
_____ Wait and Watch

COMMENTS:

_____
Contact Made

Date	To Whom	By Whom	Information

Appendix B

SCHOOL DISTRICT No. 65 PROGRAM IN EARLY CHILDHOOD DEVELOPMENT

Miller School
425 Dempster Street
Evanston, Illinois 60201
(312) 328-9505

Dear Parents,

We are pleased to inform you that your child performed successfully in all areas of our pre-school screening. This (did) (did not) include Vision and Hearing Screening. _____ *strengths were*
(Child's Name)
_____.

If you would like details concerning your child's performance, please feel free to contact us.

The staff of the Program in Early Childhood Development has been very encouraged by the response to our community screening.

Thank you for your cooperation.

Sincerely,

'78

Appendix C

SCREENING RECORD FORM

SCREENING SITE _____

SCREENING DATE _____

NAME	NO.	SEX	PRE-SCHOOL	BIRTH DATE	HEARING	VISION	SOCIAL-EMOTIONAL	SPEECH	FINE MOTOR	GROSS MOTOR	COGNITION	CASE STATUS

Appendix D

FACE SHEET

CHILD'S NAME AND NO. _____ B.D. _____ AGE _____

ADDRESS _____ TELEPHONE NO. _____

PARENT OR GUARDIAN _____

PRE-SCHOOL _____ DIRECTOR _____

SCREENING DATE _____

CASE STATUS	DATE
Follow-up _____	_____
Wait and Watch _____	_____
Follow-up Completed _____	_____

Appendix E

CHILD'S NAME _____

DATE	INFORMATION	INITIALS

Appendix F

SAMPLE CARD

Child's Name and Identification Number	Birthdate	Sex
Address	Telephone No.	Screening Date
Pre-school Program		
PECD Staff Member	Statement of Problem	

Record of Follow-up

Appendix G

SCHOOL DISTRICT No. 65 PROGRAM IN EARLY CHILDHOOD DEVELOPMENT

Miller School
425 Dempster Street
Evanston, Illinois 60201
(312) 328-9505

DATE _____

Dear_____,

The staff of District No. 65, Program in Early Childhood Development appreciates your allowing your child _____ to participate in the screening program; I would now like the opportunity to share the results with you.

Please contact me at 328-9505 at your earliest convenience. If I am not in, please leave your name, number and the most convenient time to return your call.

Thank you for your cooperation.

Sincerely,

Appendix H

STAFF MEMBER _____
DATE _____

MONTHLY SUMMARY REPORT

SCREENING DATE	CHILD'S NAME AND BIRTHDATE	STATEMENT OF PROBLEM	INTERVENTION STATUS

Appendix I

DISTRICT NO. 65 PROGRAM IN EARLY CHILDHOOD DEVELOPMENT

Pre-School Social and Developmental History Form

DATE _____

I Family

Name of Child _____ Code _____

Date of Birth _____ Place of Birth _____ Sex _____ Age _____

Father's Name _____ Age _____ Education _____ Occupation _____

Mother's Name _____ Age _____ Education _____ Occupation _____

Guardian — Mother _____ Father _____ Both _____

Marital Status _____ Married _____ Single _____ Divorced _____

Child lives with — Mother _____ Father _____ Both _____

Address _____

Telephone Number _____

Language Spoken in Home _____

Source of Referral _____

_____

_____

Reason for Referral _____

_____

_____

Number of children in family _____

Names	Age
_____	_____
_____	_____
_____	_____
_____	_____

Is child presently enrolled in a Pre-School — Yes _____ No _____

Name of School _____

Has child ever attended another pre-school _____

When _____

Reason for leaving _____

Will child enter kindergarten in the fall (Sept.) _____

Name of School _____

Is child presently receiving services from a Medical or Social Agency? _____

_____

II DEVELOPMENTAL HISTORY

A. Prenatal and Birth History

1. Serious Illness _____
2. Accidents _____
3. German Measles _____
4. Length of Labor _____
5. Caesarean _____
6. Breech _____
7. Full Term _____

8. Premature _____
9. Toxemia _____
10. Other Complications _____
11. Birth Weight _____ lbs. _____ ozs.
12. Birth Injuries _____
13. Did baby require any special medical attention during first few weeks of life? _____
14. Did baby have any problems following birth (breathing, jaundice, etc.) _____
15. Did baby have a PKU or other blood tests at birth? _____

B. Gross and Fine Motor Development

1. Sucking – Well established at birth _____ feeding problems _____
2. At what age did child sit? _____ Walk? _____
3. Does your child seem awkward and uncoordinated? _____
4. Has child learned to ride a tricycle? _____
5. Is child able to throw and catch a ball? _____
6. Is he able to button his coat without difficulty? _____
7. Does he run as fast as other children his age? _____
8. Can he hold a pencil properly? _____
9. Is he able to feed himself properly? _____

III MEDICAL

A. Has your child ever had (Please check):

1. Frequent stomach aches _____
2. Convulsions _____
3. Head Injury _____
4. Periods of unconsciousness _____
5. Prolonged high fever _____
6. Three or more ear infections _____
7. Red Measles _____
8. Allergies _____
9. Strep Infections _____
10. Has child had a physical in the last 12 months? _____
    Name of Doctor _____ Physical Defects _____
11. Surgery _____ Type _____ Date _____
12. Hospitalization _____ Date _____ Length of time _____

B. VISION

1. Does child wear glasses? _____
2. Does the child appear to have trouble seeing? _____
3. Does the child squint when looking at something? _____
4. Do his eyes tend to cross? _____
5. Does child hold objects up very close to his eyes? _____
6. Does he sit unusually close to the TV Screen? _____

C. HEARING

1. Does the child appear to have trouble hearing? _____
2. Is he a mouth breather? _____
3. Does he turn the TV to a very high volume? _____
4. Has the child ever received medical treatment for his ears? _____

IV SPEECH AND LANGUAGE

1. At what age did child speak his first word _____, two and three words together _____, sentences _____?
2. Does child understand and respond when you or others talk to him? _____
3. Is the child able to speak most sounds correctly? _____
4. Is the child afraid to talk? _____
5. Are you aware of any speech problem that the child may have? _____

V PSYCHO-SOCIAL DEVELOPMENT

Does child:

1. Seem happy most of the time?	Yes or No
2. Have temper tantrums?	Yes or No
3. Prefer to play alone most of the time?	Yes or No
4. Need constant reassurance	Yes or No
5. Seem easily distracted or overactive?	Yes or No
6. Have any excessive fears of the dark, etc.?	Yes or No
7. Perform tasks with confidence?	Yes or No
8. Become frustrated easily?	Yes or No
9. Follow directions as well as most children his age?	Yes or No
10. Does child still wet the bed?	Yes or No
11. Does child soil himself?	Yes or No
12. Seem overly shy and quiet?	Yes or No
13. Seem extremely well behaved for his age?	Yes or No
14. Seem overly loving toward members of his family?	Yes or No
15. Seem resistive to change?	Yes or No
16. Consistently act without thinking?	Yes or No
17. Seem fearful or untrusting of people?	Yes or No
18. Control or dominate his family and friends?	Yes or No
19. Play better with toys than with other children?	Yes or No
20. Get along well with other children?	Yes or No
At Home	Yes or No
At School	Yes or No
21. Seem to be a leader?	Yes or No
22. Seem to be a follower?	Yes or No

23. Please list any additional comment you feel may be of help to us.

_____

_____

_____

VI FAMILY

1. Number of people in household, age, relationships, and disciplines

_____

_____

2. Living arrangements

_____

_____

3. Communication patterns

_____

_____

_____

VII OBSERVATION OF CHILD

1. Child's appearance_____
2. Speech_____
3. Socialization tasks_____
4. Motor development_____

VIII IMPRESSIONS:

IX RECOMMENDATIONS:

Appendix J

PROGRAM IN EARLY CHILDHOOD DEVELOPMENT

DATE _____

I, _____ Father / Mother / Guardian of _____ (child's name)

hereby give my consent to the Program in Early Childhood Development to obtain or release information regarding

_____ (child's name) from or to the following sources:

1. _____ (name) (address)
2. _____ (name) (address)
3. _____ (name) (address)

Signed: _____

Address: _____

Appendix K

DISTRICT No. 65 PROGRAM IN EARLY CHILDHOOD DEVELOPMENT

SPEECH CASE HISTORY

DATE _____

IDENTIFICATION

CHILD'S NAME _____ BIRTHDATE _____

AGE _____ SEX _____ ADDRESS _____

CITY _____ PHONE NO. _____

FATHER: NAME _____ ADDRESS _____

AGE _____ OCCUPATION _____ EDUCATION _____

MOTHER: NAME _____ ADDRESS _____

AGE _____ OCCUPATION _____ EDUCATION _____

PHYSICIAN: _____
(name) (address)

REFERRED: _____
(name) (address)

SCHOOL CHILD ATTENDS: _____

ADDRESS: _____

PERSON FILLING OUT QUESTIONNAIRE: NAME _____

RELATIONSHIP TO CHILD _____

OTHER CHILDREN IN FAMILY: NAME AGE GRADE

_____

_____

_____

Description of Speech Problem

Describe, in your own words, your child's speech problem. If more room is needed, continue on the back of this sheet.

_____

_____

_____

Speech Development

During the first year, other than crying, would you say that the child was: a silent baby_____ a very quiet baby_____ an average noisy baby_____ a very noisy baby_____.

At what age did he say his first words?_____

At what age did he have a name for almost everything?_____

At what age did he use word combinations like "Want cookie" or "Me Out"?_____

_____

At what age did he use more complete short sentences?_____

Did speech learning ever seem to stop for a period? If so, describe:_____

_____

Description of how speech and language developed, including speed of development:_____

_____

_____

Has there been a change in the child's speech in the last six months?_____

If so, describe:_____

_____

Has the child ever spoken better than he does now?_____

If onset of speech problem was sudden, please describe circumstances:_____

_____

Does the child seem to have any difficulty hearing?_____ If so, please describe:_____

_____

Estimate the child's need to communicate (past and present):_____

_____

_____

_____

Does the child comprehend the speech of others, with and without accompanying gestures?_____

Describe the child's present communication including amount and spontaneity of speech:_____

_____

_____

_____

Estimation of intelligibility of child's speech (differentiate between mother, father, stranger, etc. if relevant): Child is understood if topic is known_____ words understood now and then_____ completely unintelligible_____ only gestures understood_____ other description_____

Does the child seem to be aware of a speech difference? If so, describe:_____

_____

Do any of his playmates call attention to his speech?_____

What efforts have been made to help the child talk better?_____

_____

Is there a history of speech or language problems, hearing disorders or physical defects in the family? (siblings and relatives)_____

_____

Has the child had a speech examination prior to this time?_____

Where and with whom?_____

_____

Has the child ever had a hearing evaluation?_____

Where and with whom?_____

_____

Has the child ever received, or is he receiving now any kind of therapy?_____

_____

Where and with whom?_____

_____

_____

_____

_____

ADDITIONAL INFORMATION

Is there any additional information which you feel will help us to understand your child and his problem better, please describe:

_____

_____

_____

_____

_____

_____

_____

_____

Adapted from Northwestern University, Speech Clinic, Evanston, Illinois, Speech Information Form.

Appendix L

DISTRICT No. 65 PROGRAM IN EARLY CHILDHOOD DEVELOPMENT

Miller School
425 Dempster Street
Evanston, Illinois 60201
(312) 328-9505

DATE _____

CHILD'S NAME _____ AGE _____
DATE OF BIRTH _____ PRE SCHOOL _____
PARENT OR GUARDIAN _____
ADDRESS _____ TELEPHONE NO. _____
SCREENED AT _____ ON _____
REFERRED BY _____
REFERRED TO _____
REFERRAL DATE _____
STATEMENT OF CONCERN: _____

Please return this form to: Program in Early Childhood Development
Miller School
425 Dempster Street
Evanston, Illinois 60201
or call 328-9505 with information.

CHILD'S NAME _____
BIRTHDATE _____ AGE _____
ORGANIZATION/AGENCY _____
DATE PARENT CONTACTED AGENCY _____
PRESENT STATUS OF CLIENT WITH AGENCY _____

SIGNED: _____

Appendix M

INTERVENTION PRESCRIPTION

NAME _____ BIRTHDATE _____

DATE _____ STAFF MEMBER _____

AREAS OF STRENGTH:

AREAS OF WEAKNESS:

LONG TERM GOALS/OBJECTIVES:

Appendix N

LESSON PLAN

INDIVIDUAL/GROUP

NAME _____ AREA _____ DATE _____

STAFF MEMBER _____ ATTENDANCE _____

I. OBJECTIVES FOR DAY
1.

II. ACTIVITIES
1.

III. COMMENTS
1.

Appendix O

LESSON PLAN

MULTIDISCIPLINARY GROUP

CONCEPT _____

DATE _____ ATTENDANCE _____

FINE MOTOR _____ OBJECTIVES _____

Activities/ Materials 1.

Observations 1.

GROSS MOTOR _____ OBJECTIVES _____

Activities/ Materials 1.

Observations 1.

SPEECH AND LANGUAGE _____ OBJECTIVE _____

Activities/ Materials 1.

Observations 1.

FREE PLAY _____ OBJECTIVE _____

Appendix P

OBSERVATIONAL COMMENTS

CHILD_____ STAFF MEMBER_____

DATE _____ ATTENDANCE _____

SPEECH AND LANGUAGE:

FINE MOTOR:

GROSS MOTOR:

FREE PLAY:

Appendix Q

PECD PARENT GROUP

Three times a year the PECD Psychologist and Nurse lead a group of parents who would like to learn more about their interaction with their children. The groups get involved in discussion, role play, and trying out new behavior. Parents learn more about how their own personality affects the personality growth of their children. The groups meet on Monday evenings from 7:30 to 9:00 p.m. for six (6) weeks. If you are interested in being a part of the next group, please fill out the following:

NAME: _____

ADDRESS: _____

CITY: _____

STATE & ZIP: _____

TELEPHONE: _____

Appendix R

DOE, JOHN **SCREENING – FEBRUARY 1973**

INDIVIDUAL PROFILE	NUMBER CORRECT	T-SCORE
.63 Recall of Objects	6/ 6	66.6
.55 Classification	8/ 8	58.2
.54 Visual Motor Memory	3/ 3	56.4
.53 Paired Ass. Learning	4/ 4	56.3
.52 Jumping	3/ 3	54.7
.52 Blocks	4/ 4	54.5
.51 Balance	3/ 3	54.0
.51 Matching	4/ 4	54.0
.51 Discrimination	4/ 5	53.8
.51 Number Concepts	12/12	53.8
.51 Symbol Discrimin.	9/10	53.5
.51 Percept-Motor Skills	3/ 3	53.2
.50 Rote Counting	4/ 4	52.7
.50 Figure Ground Discrimin.	5/ 5	52.3
.50 Obstacle Course	3/ 3	52.2
.49 Imitation	3/ 3	52.1
.49 Body Identity	3/ 3	52.0
.49 Bead Stringing	4/ 4	51.3
.49 Recall of Words	7/12	51.3
.38 Bean Bag Catching	2/ 3	40.0
.31 Serial Learning	2/ 4	32.4

This child's relative strengths are
Recall of Objects
Classification
Visual Motor Memory
Paired Ass. Learn.

This child's relative weaknesses are
Bean Bag Catching
Serial Learning

To supplement these weaknesses he should be given special activities. The use of his relative strengths as an approach to teaching other skills may hold the greatest potential for his success.

Appendix S

PROGRAM IN EARLY CHILDHOOD DEVELOPMENT

425 Dempster Street
Evanston, Illinois 60201

PROGRESS REPORT

NAME:
ADDRESS:
PHONE No.:
BIRTHDATE:
DATE OF REPORT:
SEX:
SCHOOL STATUS: (Child entering Kindergarten, September, 19)

Period of therapy from _____ to _____
Child seen at _____
Therapy Schedule:
Sessions per week _____
Length of session _____
Number of visits _____
Clock hours individual treatment _____
Clock hours group treatment _____
Total hours treatment _____

STATEMENT OF PROBLEM AT ONSET OF TREATMENT

a. Include statement of diagnosis
b. Brief summary of status during first few visits.
c. Note if child has had any previous treatment and where.

This section should be written *by* around the fourth visit and then placed in the child's file; the rest of the report is then finished at the termination of therapy.

EXAMPLE:

a. Problem in numbers concepts
b. Eye-hand coordination difficulty

SUMMARY OF TREATMENT

a. Outline of goals and objectives for therapy
b. Outline of approaches, materials, and procedures

EXAMPLE:

a. First, worked on rote counting from one to ten; then tried objects to numbers 1 one – 1 ball
2 two – 2 blocks etc.
b. To improve eye-hand coordination, exercises involving drawing, cutting, puzzles, mirroring were used, etc.

PROGRESS

a. Relate the progress the child made to objectives and procedures.

EXAMPLE:

a. Child now can count to ten and has the accompanying number concepts, although inconsistent, etc.
b. Child can complete dot to dot tasks, follow maze drawings, copy numbers and has improved fine motor coordination in general.

Any comments concerning effectiveness of procedures, child's attitude, attendance, etc., should be mentioned at the conclusion of this section.

RECOMMENDATIONS:

a. Include statement as to dismissal or continued treatment.
b. Include statement as to type of treatment — e.g. specialist, in class, or work at home.
c. Include statement as to any further testing.

EXAMPLE:

a. Child still needs work on number concepts; this could be incorporated into the classroom setting.
b. In eye-hand coordination, he has seemingly "caught up to his age level" and no further concentrated work in this area is needed.

_____
Staff Member's Name Title or Position

Adapted from the University of Illinois, Speech Clinic, Champaign, Illinois, Progress Report Form.

Appendix T

SCHOOL DISTRICT 65 PROGRAM IN EARLY CHILDHOOD DEVELOPMENT

NAME _____ PARENT/GUARDIAN _____

ADDRESS _____ PHONE _____

BIRTHDATE _____ AGE (Time of Screening) _____

SCREENED AT _____ ON _____

VISION

HEARING

SPEECH AND LANGUAGE

COGNITION

GROSS MOTOR

FINE MOTOR

SCREENING SUMMARY

AGNOSTIC EVALUATION/FOLLOW-UP DATA

PLEMENTED INTERVENTION

ECOMMENDATIONS

Appendix U

PECD PROGRAM MILLER SCHOOL 425 DEMPSTER STREET

PECD REPORT TO SCHOOL NURSE

NAME _____ B.D. _____ SCREENING DATE _____

ADDRESS _____ PARENT/ GUARDIAN _____ RESCREENING DATE _____

- ☐ SPEECH & LANGUAGE:
- ☐ GROSS MOTOR:
- ☐ FINE MOTOR:
- ☐ COGNITION:
- ☐ VISION:
  - ☐ Glasses
  - ☐ Report enclosed
  - ☐ Other
- ☐ HEARING:
  - Treated
  - Report enclosed
  - Other
- ☐ MEDICAL:
- ☐ ADDITIONAL STAFF CONTACT:
- ☐ OTHER AGENCY (KNOWN) OR PROFESSIONAL CONTACT:

FUTURE SCHOOL _____ DATE _____ SIGNATURE _____

DISTRICT #65 PROGRAM IN EARLY CHILDHOOD DEVELOPMENT

Miller School
425 Dempster Street; Evanston, Illinois 60201
(312) 328-9505

AGE NORMS FOR SIEDS

July, 1974

The Screening Instrument for Evaluating Developmental Skills (SIEDS) was originally designed to identify "...children for whom failure or problems in kindergarten are probable.."[1] Use of the instrument has indicated that children's performances vary with age. In order to more effectively utilize the screening data, the Program in Early Childhood Development (PECD) Staff felt that age specific norms would be a useful tool. This means of analyzing a child's performance adds a new dimension to describing a child's strengths as exhibited on the screening. As discussed in Part V "Dissemination", of School-Community Program in Early Childhood Development (Holliday & Olswang, 1974), a child's performance on the SIEDS is evaluated in terms of relative strengths (and weaknesses). That is a child's performance on each screening task is ranked relative to his own overall performance. A child could therefore exhibit minor difficulties on an item and yet still have it be a relative strength. Providing age norms allows the examiner to determine a child's strengths, not only in relation to his own performance on other tasks, but also in relation to the performance of other children his age. According to the philosophy of PECD, both types of strengths are important in describing the developmental skills of pre-school children. However, to say a child exhibits a weakness in an area as compared to other children his age is only a partial evaluation. It may be that the demonstrated area of weakness is in fact one of the stronger areas of the child's performance. Only through such an approach can instructional programs be designed with the objective of supplementing weaknesses by building on strengths.

The standardization of the screening instrument was based on a community-wide sample of 692 children, aged 36 through 71 months (the age range for which the instrument was designed). All subjects were administered

[1] Holliday, F.B. and Olswang, L. School-Community Program in Early Childhood Development, 1974, pg. V.

the final battery[2] of the SIEDS, as described in School-Community Program in Early Childhood Development (Holliday and Olswang, 1974), during the period of September, 1973 through July, 1974. This was a mixed racial and ethnic population of 392 males and 297 females of varied socio-economic backgrounds, who participated in a routine screening prior to kindergarten entry. Eleven age groups were defined - 36-44, 45-48, 49-50, 51-52, 53-54, 55-56, 57-58, 59-60, 61-62, 63-64, and 65-71 months. The groupings were drawn in two month intervals with the exception of the first two and last groups, where the interval was changed due to the decreased population size at both ends of the age range. The small number of cases at these ages (36-48 and 65-71 months) was a result of the program's target population, ie., primarily four year olds who would be entering kindergarten within one year.

As the SIEDS is designed, only three of the seven areas are conducive to age norming; they are Gross Motor, Cognition, and Fine Motor. These areas are composed of individual tasks, some of which are adapted from other instruments. The combination of these tasks and the ones created by the PECD Staff, have not been analyzed for age norms. The other areas of Vision, Hearing, Speech and Language have standardized norms built into the tasks, and the techniques used for Social-Emotional evaluation are not amenable to age norming.

The first step then for determining age norms for the instrument was to compute cross tabulations for the total population, which gave scores for each age group by each major area (Gross Motor, Fine Motor, and Cognition). For each age group a number of experimental cut-off points were determined. Secondly, by computing a similiar cross tabulation of only those children selected for follow-up in each area, it was determined that the PECD Staff in practice regularly selected for follow-up those children scoring in the lowest 10%. Thus the criteria previously used for determining weaknesses was professional judgement based on existing developmental scales. The statistically generated normative data illustrated that for this particular population, children designated subjectively as exhibiting developmental problems were in fact

[2]A preliminary analysis of the data collected on earlier forms of the SIEDS was conducted. This data is not presented here as it is no longer applicable since the present instrument has changed considerably in content.

receiving scores in the lowest 10%. This 10% level was therefore used as the basis for establishing the norms.

Table I

Lowest 10% Cut-off Points

Age in Months	Gross Motor (24)	Cognition (52)	Fine Motor (36)
36-44	15	20	26
45-48	18	21	26
49-50 (A)	20	30	31
51-52	21	33	32
53-54	21	32	32
55-56	22	34	31
57-58	22	36	33
59-60	22	34	33
61-62	22	38	34
63-64 (B)	22	32	30
65-71 (B)	18	40	30

Table I illustrates the eleven age groupings and the corresponding cut-off score for the lowest 10% of the population for the areas of Gross Motor, Cognition and Fine Motor. The number in parentheses beside the area title indicates the total possible points on all tasks for that area. Inspecting for consistency across the ages, minor irregularities in the distribution can be noted. A substantial increase in scores at the 49-50 month age level (A) may be due to the rapid developmental growth that occurs at this age. The irregularities at the oldest two age groups (B) are due in part to the small population size. Further these children are older than the average age of a child entering kindergarten and this late entry was often a result of some developmental problem. Thus these older groups may be contaminated by a large number of children exhibiting moderate to severe weaknesses. The other minor irregularities in the distribution were presumably due to chance fluctuations of sampling and were eliminated by smoothing, as illustrated in Table II.

Table II
Adjusted Data
Lowest 10% Cut-off Points

Age in months	Gross Motor (24)	Cognition (52)	Fine Motor (36)
36-44	13	20	26
45-48	18	21	26
49-50	20	30	31
51-52	21	33	32
53-54	21	33	32
55-56	22	34	32
57-58	22	36	33
59-60	22	36	33
61-62	22	38	34
63-64	22	38	34
65-71	23	40	35

The normative data in Table II gives an indication as to the nature of a child's performance in comparison with the performance of other children in the same age group. Further the expectations for different aged children will thus be further clarified and provide more information for determining a child's strengths and weaknesses. To utilize Table II, the examiner should first find the corresponding age group for an individual child. The child's total score for each area should be computed and then compared to the normative data as presented in Table II. If the child's score is equal to or less than the norm for his age, then the child is performing in the lowest 10% of this age group, and appropriate intervention procedures should be considered. Application of these norms to other populations must be made with some reservations. One must recognize that they are based on a relatively small, heterogeneous population in one school district. For this reason, the norms have been expressed in terms of actual scores, since in the face of variability in populations these scores are more likely to represent comparable information. Thus for other populations, these cut-off points may identify either a greater or lesser proportion of the total number screened than the 10% in the PECD Evanston population.

As the SIEDS is defined, no one task can alone identify a strength or weakness in a given area. It is therefore essential when evaluating a child to examine 1) his total performance on the entire instrument, 2) his performance in each area, and 3) his performance on related individual items. The third phase of the evaluation is most helpful in describing overlapping skills in the developmental areas and in conceptualizing general areas of strength and weakness. As described in the SIEDS Inter - Item Correlation Study, certain individual tasks were found to be highly correlated using the Pearson "r".

In an effort to utilize this information most effectively, it seemed important to determine age norms for those items that had a substantial positive correlation and that seemed to be related conceptually or theoretically. Table III describes these individual tasks that were grouped, plus the area of the SIEDS in which the item is located and the total points of the tasks comprising each group.

Table III

Group I: Classification (Cog), Symbol Discrimination (Cog), Paired Associate Learning (Cog)
Total = 21 points

Group II: Recall Objects (Cog), Serial Learning (Cog), Visual Sequential Memory (Cog)
Total = 13 points

Group III: Rote Counting (Cog), Number Concepts (FM)
Total = 7 points

Group IV: Figure-Ground Discrimination (FM), Part-Whole Discrimination (FM), Perceptual Motor Items (GM), Block Structures (FM)
Total = 15 points

Group V: Block Structures (FM), Bead Stringing (FM), Puzzle Matching (FM)
Total = 16 points

Group VI: Imitation of Movement (GM), Obstacle Course (GM), Visual Memory (GM)
Total = 9 points

Group VII: Basic Skills (Cog): Serial Learning, Recall of Objects, Symbol Discrimination, (Same, Break and Closure), Visual Sequential Memory, Paired Associate Learning, Classification (Choice)
Total = 26 points

Group VIII: Applied Skills (Cog): Rote Counting, Counting Blocks, Recall of Words, Symbol Discrimination (Rotation and/or Reversal), Classification (Reason)
Total = 26 points

To determine normative data for each of the eight groups, cross tabulation of total group scores by age intervals were generated. As in the first procedure, the lowest 10% cut-off point was determined. Once again minor irregularities in the distribution were observed. As they are presumably an artifact of the sample, they were adjusted. Table IV illustrates the eleven (11) age groupings and the corresponding cut - off score for the lowest 10% of the population for the eight (8) task groupings as defined in Table III. If a child's performance falls within the lowest 10%, this would indicate a need for follow-up action. The age norming data in Table IV allows the examiner to utilize information on individual items more effectively. Isolated skills, whether strengths or weaknesses can be grouped according to broader categories.

Table IV

Lowest 10% Cut-off Points for Grouped Items

Age in Months	Item Groups: I	II	III	IV	V	VI	VII	VIII
36-44	4	6	2	10	13	5	10	5
45-48	7	7	3	10	13	6	12	8
49-50	10	8	4	12	14	6	17	11
51-52	12	8	4	13	14	7	18	12
53-54	13	8	5	13	14	7	19	13
55-56	13	8	5	13	14	7	19	13
57-58	15	9	6	14	14	7	20	16
59-60	15	9	6	14	15	8	20	16
61-62	15	10	6	14	15	8	21	17
63-64	16	10	6	14	15	8	21	17
65-71	17	11	7	15	16	9	22	18

The conditions under which these norms should be used are so important that they need to be reiterated. First, the norms are to serve as a guide and are not to be used in isolation. They are a tool to supplement the overall evaluation of a child's performance. Second, the norms are generated from a limited data base and need to be cautiously applied to other populations.

DISTRICT #65 PROGRAM IN EARLY CHILDHOOD DEVELOPMENT

Miller School
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STATISTICAL SUMMARY REPORT

The Program in Early Childhood Development is a federally funded program now completing its third year of operation. During the existence of the Evanston, District #65 Program in Early Childhood Development from July, 1971, through July, 1974, the staff has attempted to screen all pre-school children prior to their entering kindergarten in District #65. The following summary of screening results should provide some insight into the performance of the three through five year old population on a developmental screening test. For those adopting a program format similar to the one described in School-Community Program in Early Childhood Development (Holliday & Olswang, 1974), this information should be especially useful. As participation in the program has never been mandatory, the following report describes an entirely volunteer population.

The total population of children screened between July, 1971, and July, 1974 will be reviewed. In addition the breakdown of results will be presented according to the following categories:

1) PASS - those children performing satisfactorily on all of the screening areas.
2) WAIT and WATCH - those children demonstrating a minor weakness, having difficulty completing a task, or for any reason having to terminate the screening, as due to illness or immaturity, and thus requiring that the child be screened again at a later date.
3) FOLLOW UP - those children needing to be contacted following the initial screening due to a demonstrated weakness on one or more screening areas, parent/staff concern about the child's development, or referral from other agencies.

These categories are further delineated on pages 47-49 of School-Community Program in Early Childhood Development.

This breakdown of statistical information has been prepared following numerous requests and is ment to provide only an abbreviated view of the performance of a specific population.

STATISTICAL SUMMARY REPORT

Children administered the SIEDS between July 1, 1971, and July 1, 1974

Total Number of Children Screened:	2338
Sex Breakdown:	
Male:	1264
Female:	1074
Pre-School Experience Breakdown:	
Pre-School Experience:	2036
No Pre-School Experience:	302
Overall Results:	
Pass:	1502
Wait and Watch:	44
Follow-Up:	792
Results by Individual Screening Areas:	
Vision:	
Wait and Watch:	1
Follow-Up:	54
Hearing:	
Wait and Watch:	0
Follow-Up:	67
Gross Motor:	
Wait and Watch:	18
Follow-Up:	99
Cognition:	
Wait and Watch:	6
Follow-Up:	150
Fine Motor:	
Wait and Watch:	5
Follow-Up:	95
Speech and Language:	
Wait and Watch:	27
Follow-Up:	167
Social-Emotional:	
Wait and Watch:	7
Follow-Up:	324*

*During the screening, parents are given the opportunity to request a conference with the Staff Psychologist. Such requests are considered part of the follow-up procedure, even though the follow-up action may be an answer to an inquiry and require only a brief telephone conversation. A more realistic evaluation of the actual intervention provided would be approximately one-third of the total number of children in follow-up in the Social-Emotional area.

SCREENING INSTRUMENT FOR EVALUATING DEVELOPMENTAL SKILLS

INTER-ITEM CORRELATION STUDY

The Program in Early Childhood Development (PECD) was initially funded in the summer, 1971, under Title III ESEA (Elementary and Secondary Education Act), of the Department of Health, Education and Welfare. During the first several months of existence, the staff spent a considerable amount of time researching existing pre-school test instruments in the various disciplines. None of these existing devices in total met the needs of the program, either because of their length, content or philosophy. It was following this research that the PECD staff developed the Screening Instrument for Evaluating Developmental Skills, hereafter referred to as SIEDS. The SIEDS is based upon existing developmental norms in the areas of Speech and Language, Fine Motor, Gross Motor, and Cognitive Development. In addition, tasks were selected for inclusion on the screening instrument that would evaluate the pre-school child's perceptual skills. The SIEDS was designed to be administered quickly and easily, and to provide information about the individual child's strengths and weaknesses.

As described in School-Community Program in Early Childhood Development (Holliday and Olswang, 1974), the SIEDS is composed of six screening stations (Social Emotional, Vision and Hearing, Fine Motor, Gross Motor, Speech and Language, and Cognition). For each of the four areas of Fine Motor, Gross Motor, Speech and Language, and Cognition, items were selected based on their individual and combined value in describing the developmental level of the pre-school child. It is important to reiterate at this point that the SIEDS does not yield a particular score or set of scores (equivalent to a learning or intelligence quotient), but rather a description of the individual child's skills in the developmental areas. Therefore, the utility of the instrument lies in the staff's ability to 1) identify the child's level of performance, 2) recognize any overlap of skills, and finally 3) conceptualize general areas of strength and weakness for diagnostic purposes and in planning individual instructional programs.

As individual items were selected for the instrument because of their relevance for determining levels of development and their apparent interrelationship, it was hypothesized that a child's performance on such tasks would be similar. In an effort to discover if these relationships existed in the application of the instrument and to evaluate at least one measure of reliability of the instrument (internal consistency), a series of inter-item correlation coefficients was computed. First, items were selected for comparison which subjectively or intuitively seemed to be related. Table I lists these individual tasks plus the general area of the screening instrument in which the item is located.

Table I

Hypothesized Inter-related Items

Balance (GM)/Obstacle Course (GM)
Balance (GM)/Jumping (GM)
Body Identification (GM)/Imitation of Movement (GM)
Body Identification (GM)/Obstacle Course (GM)
Imitation of Movement (GM)/Obstacle Course (GM)
Imitation of Movement (GM)/Jumping (GM)
Imitation of Movement (GM)/Visual Motor Memory (GM)
Visual Motor Memory (GM)/Recall of Objects (Cognition)
Serial Learning (Cog)/Recall of Objects (Cog)
Serial Learning (Cog)/Recall of Words (Cog)
Serial Learning (Cog)/Paired Associate Learning (Cog)

Table I cont'd

Rote Counting (Cog)/Recall of Words (Cog)
Rote Counting (Cog)/Number Concepts (FM)
Recall of Objects (Cog)/Recall of Words (Cog)
Recall of Objects (Cog)/Paired Associate Learning (Cog)
Paired Associate Learning (Cog)/Classification (Cog)
Symbol Discrimination (Cog)/ Classification (Cog)
Classification (Cog/Number Concepts (FM)
Block Structures (FM)/Bead Stringing (FM)
Block Structures (FM)/Chalkboard Percpetion Items (GM)
Part-Whole Discrimination (FM)/Chalkboard Perception Items (GM)
Part-Whole Discrimination (FM)/Figure Ground Discrimination (FM)
Part-Whole Discrimination (FM)/Symbol Discrimination (Cog)
Language (Speech and Language)/Classification (Cog)
Language (S & L)/Paired Associate Learning (Cog)
Language (S & L)/Symbol Discrimination (Cog)
Language (S & L)/Body Identification (GM)
Language (S & L)/Number Concepts (FM)

With an N=764, the paired items in Table I were analyzed using the Pearson Product Moment Correlation. These inter-item correlations between subject scores were computed from the total population of pre-school children (ages 3.0-5.5) screened between February and August, 1973. The sample included both children performing satisfactorily on the screening and those exhibiting definite weaknesses (ie. children receiving follow-up services). Of the twenty-eight (28) paired items listed in Table I, only eleven (11) were identified as having a substantial positive correlation, or an $r \geq .35$. Table II lists these items and their correlation coefficients.

Table II

Balance/Obstacle Course	.4383
Balance/Jumping	.3943
Imitation of Movement/Obstacle Course	.4863
Imitation of Movement/Jumping	.4084
Imitation of Movement/Visual Motor Memory	.4385
Paired Associate Learning/Classification	.3466
Symbol Discrimination/Classification	.5605
Block Structures/Bead Stringing	.3581
Part-Whole Discrimination/Figure Ground Discrim.	.5689
Language/Classification	.4550
Language/Body Identification	.4190

These results indicate that a substantial number of the 764 pre-school children screened between February and August, 1973, performed similarly on particular pairs of items, ie. those listed in Table II. Items were selected for inclusion on the screening instrument based on 1) their reflection of existing developmental norms in the area of Speech and Language, Cognition, Fine Motor, and Gross Motor, and 2) their apparent interrelationship and combined value in describing levels of performance. In light of this item selection process, the small number of highly correlated items was somewhat surprising to us. However, the fact that there was a substantial relationship between tasks in terms of individual performances, gave rise to a second model for analyzing the data.

Since, as demonstrated, some items were correlated when the population included all children regardless of performance level, then it seems reasonable to hypothesize that particular items would be more highly correlated for the population of only those children exhibiting weaknesses on the instrument. More specifically, a child demonstrating a weakness on one item might be expected to have difficulty with those other items that are closely related in terms of performance, and therefore that there would be a higher correlation between these items. This kind of information has important implications for learning how to most effectively utilize the screening results. Inter-item correlation coefficients computed for the population (N=259) are presented in Table III. This group included only those children who demonstrated definite weaknesses on the SIEDS and on that basis were categorized as either "follow-up" or "wait and watch" cases, with recommendations for intervention. The results reported in Table III reflect those items on which children who had demonstrated difficulty on the screening instrument, performed similarly. Such an observation is most important for understanding how to best use the information collected on the SIEDS. More specifically, this analysis ilustrated that if a child exhibits a weakness on a particular item, eg. balance, it would be most important to examine his performance on correlated items, eg. imitation of movement, jumping, etc., as it is highly probable that the child will perform similarly on them.

Table III

Balance/Imitation of Movement	.5248
Balance/Jumping	.5462
Balance/Chalkboard Perception Items	.4068
Balance/Visual Motor Memory	.4837
Jumping/Imitation of Movement	.5703
Jumping/Visual Motor Memory	.4988
Body Identification/Imitation of Movement	.4265
Imitation of Movement/Visual Motor Memory	.6297
Imitation of Movement/Chalkboard Perception Items	.4730
Imitation of Movement/Obstacle Course	.4065
Obstacle Course/Chalkboard Perception Items	.4779
Chalkboard Perception Items/Visual Motor Memory	.4469
Rote Counting/Symbol Discrimination	.3764
Recall of Words/Symbol Discrimination	.8435
Symbol Discrimination/Paired Associate Learning	.5262
Symbol Discrimination/Classification	.6207
Paired Associate Learning/Block Structures	.4701
Paired Associate Learning/Classification	.4168
Classification/Block Structures	.5411
Classification/Number Concepts	.4981
Block Structures/Bead Stringing	.4413

Block Structures/Figure Ground Discrimination	.4595
Block Structures/Number Concepts	.6086
Figure Ground Discrimination/Number Concepts	.7412
Part-Whole Discrimination/Number Concepts	.6751
Part-Whole Discrimination/Figure Ground Perception	.5724
Part-Whole Discrimination/Chalkboard Perception Items	.3377
Language/Body Identification	.4190
Language/Rote Counting	.3372
Language/Classification	.4550
Language/Paired Associate Learning	.3123
Language/Total Cognition	.4812

In an effort to utilize the information in Table III most effectively, an attempt was made to group those items that were highly correlated and that seemed to be related conceptually or theoretically. This analysis of the data yielded the Screening Checklist, Table IV. The vertical listing contains specific items on the SIEDS; horizontally across the top of the page are labels signifying the following conceptual groups, abstraction, language, perception, and body awareness (initialed A, L, P, and BA). Screening items that are correlated (r=.34 or larger) are indicated by a hexagon connected by a vertical and horizontal line, and grouped under the appropriate conceptual heading. More specifically, the following items showed a substantial correlation: classification, paired associate learning, symbol discrimination, number conepts, and language skills. Theoretically or conceptually it might be hypothesized that the reason there is a relationship between these items is that they all involve some form of abstract reasoning skills. Similarly, if a child performs poorly on figure ground discrimination, part-whole dscrimination, block structures, and the chalkboard perception items, he might be exhibiting a weakness in his perceptual abilities. This checklist then allows the examiner to identify isolated skills, whether strengths or weaknesses, and group them according to a broader category. This method of analyzing screening data appears to have implications for eventual diagnosis of weaknesses.

In practice the checklist is used in the following manner during the screening staffing. Based on the criterion for follow-up, when a child's performance indicates a definite weakness in the areas of Fine Motor, Gross Motor, Speech and Language, and/or Cognition, the staffing coordinator places an X through the hexagon corresponding to those items on which the child demonstrated difficulty. For example, Child A performed poorly on the following items: classification, paired associate learning, symbol discrimination, number concepts, language, total cognition, and body identification. Table V illustrates how this would appear on the checklist. These screening results seem to indicate that Child A demonstrated difficulty in performing language related tasks. To expand on this, it appears as though this deficiency in language development is inturn influencing his ability to complete tasks involving more abstract reasoning. This follows theoretically, in that if a child exhibits difficulty at a concrete receptive and expressive language level, he will inturn have problems at the more abstract level. It would follow that the staffing recommendations would include an indepth evaluation of the child's receptive and expressive language skills.

Table IV

SCREENING CHECKLIST

(based on correlations between subject scores)

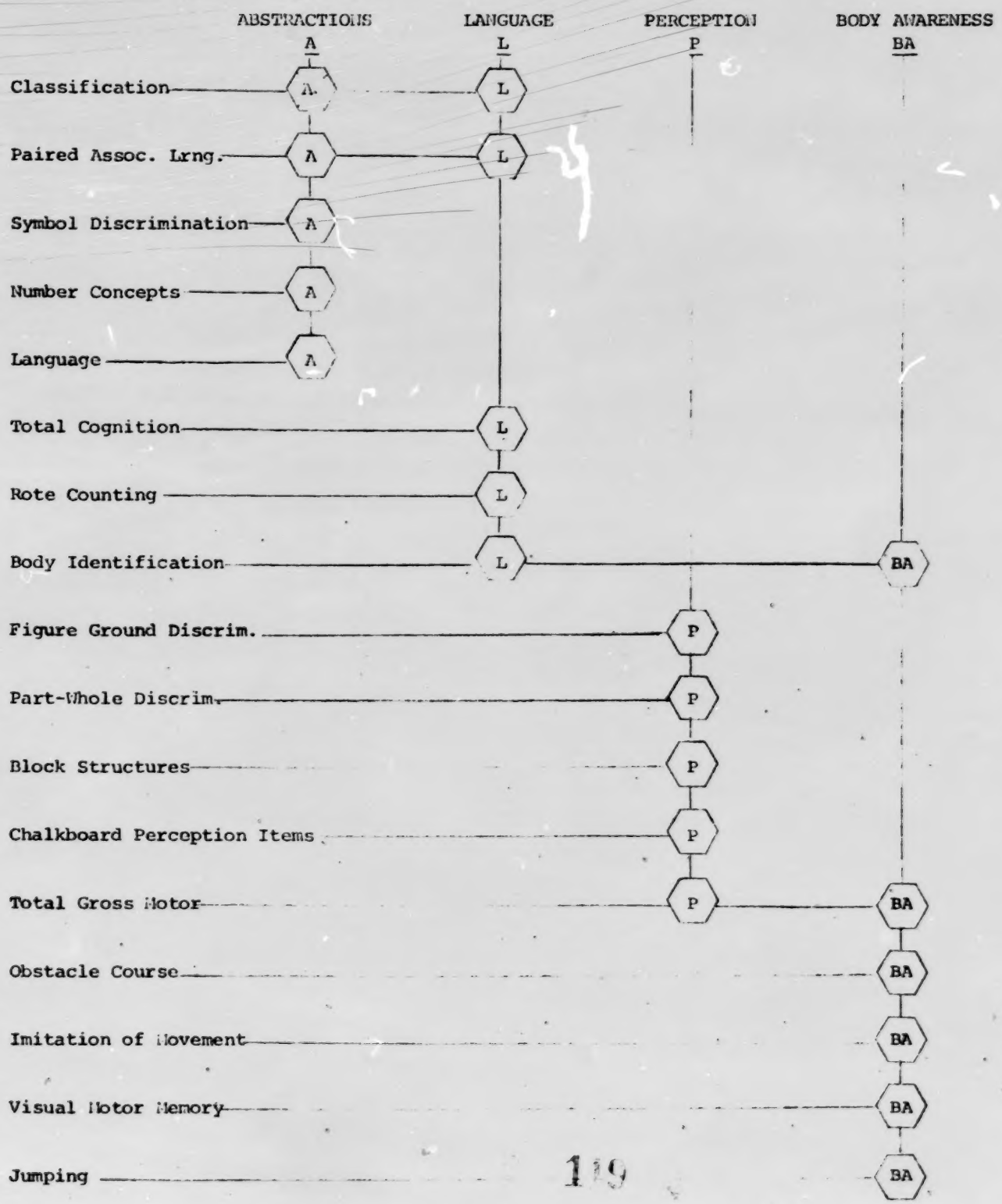
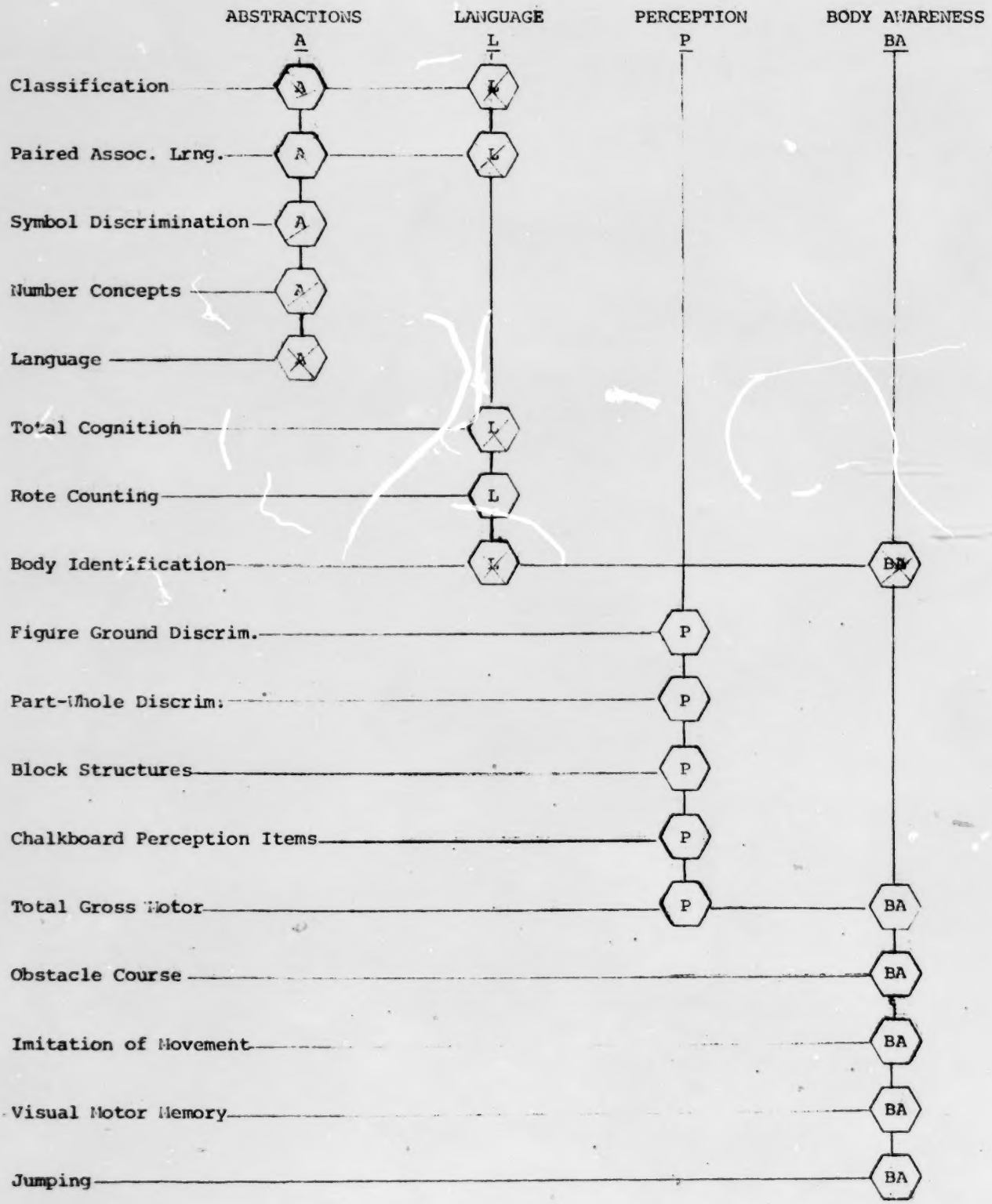


Table V
SCREENING CHECKLIST



Utilizing the data in this manner has helped to identify different ways in which children perform and for examining possible characteristics of children who exhibited difficulty on the screening. Observing overlapping areas of weakness on the screening instrument allows for more effective planning of evaluation and intervention procedures. Further this model insures the incorporation of an interdisciplinary approach in screening, diagnosing and intervention, since it requires the staff to view the many aspects of a child and his development. This has proven to be most important in reporting children's strengths and weaknesses and in minimzing the likelihood of children being "labeled" at this early stage of development and education.

In conclusion, there appears to be a high degree of internal consistency and thus inter-item reliability on the SIEDS. Further, an awareness of the relationships between items increases the utility of the instrument for 1) identifying areas of weakness, and 2) determining the content of the diagnostic evaluation and the eventual intervention perscription. This manner of examining a child's screening performance illustrates the utilization of an interdisciplinary model.